AHCCCS

Arizona Health Care Cost Containment System

Five-Year Strategic Plan
Fiscal Years 2010 – 2014
January 1, 2009

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Janet Napolitano, **Governor**
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AHCCCS

Our first care is your health care
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

January 1, 2009

Dear Arizonans:

I am pleased to submit to you the AHCCCS Strategic Plan for State Fiscal Years (SFY) 2010-2014. As in previous years, the plan was developed within the context of Arizona's economy and with a view toward the future health and economic well being of Arizona citizens. The Plan, which is revised and updated annually, describes the role of AHCCCS in this evolutionary process.

Demand by working Arizonans for AHCCCS health care coverage is closely tied to the economic well-being of the state. AHCCCS programs currently serve approximately 18% of Arizona's population. The substantial number of Arizonans covered by AHCCCS health insurance creates both short and long term concerns.

- The short-term focus is to ensure sufficient federal and state funding to meet a sizeable membership.
- The long-term focus is to manage the rise in medical costs and increase public and private health care coverage options without negatively impacting other essential state services, while improving health care quality and access to primary, preventive, and community-based services.

Our strategic plan describes how we intend to address the following key concerns:

- Health Care Costs
- Health Care Quality
- The Uninsured
- Organizational Capacity

Historically, AHCCCS has received high marks on both management and program outcomes. Our strategic plan is intended to carry that positive momentum forward to meet future challenges.

The strategic plan is also located on our web site at:

http://www.azahcccs.gov/Publications/StrategicPlanning.

Sincerely,

Anthony D. Rodgers
Director

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EXECUTIVE SUMMARY

The Arizona Health Care Cost Containment System (AHCCCS) is a public-private partnership that uses federal, state, and county funds to provide health care coverage to the state's acute and long term care Medicaid population, low-income groups, and small businesses. Unlike programs in other states that rely solely on fee-for-service reimbursement, AHCCCS makes prospective capitation payments to contracted health plans responsible for the delivery of care. The result is a managed care system that mainstreams recipients, allows them to choose their providers, and encourages prevention and the coordination of quality care. Currently, over 1.1 million Arizonans, or approximately 18%, receive health care coverage through AHCCCS.

Arizona is one of the fastest growing states in the nation, with a changing population and a changing economic climate. The increased population, coupled with a proliferation of low-wage jobs and increasing health insurance costs, has contributed to significant growth of the AHCCCS program. Moreover, this growth reflects a change in the AHCCCS population from one comprised primarily of non-working welfare recipients to one comprised of the working poor. The AHCCCS Strategic Plan should be viewed as a dynamic document that will be modified over time as the agency repositions to address shifting issues and challenges. The Plan should serve as a framework for ongoing planning, prioritizing, and budgeting.

The AHCCCS Strategic Plan for 2010-2014 begins with a description of the agency's mission and vision, an overview of the programs offered, and a summary of the environment in which these matters take place. The Plan then outlines four interrelated issues, each of which is discussed in terms of goals, recent accomplishments, strategies, and performance measures. Finally, it offers strategic initiatives that exemplify the importance and integration of all four strategic issues. The cross-cutting initiatives relate to significant populations impacted by the strategic issues described within.

Strategic Issues

Issue #1 – Health Care Costs

Health Care Costs relates to a variety of cost drivers including general price inflation, population growth, provider supply and market structure, operating costs, health status, and changes in technology. As AHCCCS expenditures consume an increasing proportion of state general funds, strategies may include restructuring provider rates to improve equity and ensure continued access to care, offering more cost-effective purchasing options (e.g., for specialized services), and maximizing non-state funding sources.

Issue #2 – Health Care Quality

Health Care Quality relates to a variety of factors that include both the scientific and personal aspects of receiving care. Preventive care, effective disease management programs, availability of providers, and accessibility to necessary services are all key components in the delivery of quality care. Strategies that may lead to improvements in quality and result in an overall reduction in costs include the use of centers of excellence, use of evidence-based treatment

guidelines, support of graduate medical education (particularly in rural areas), continued emphasis on preventive care, and facilitation of telemedicine networks.

Issue #3 – The Uninsured

The Uninsured is an important issue to Arizona. While over 1.2 million Arizonans are without health care coverage, most of them are employed. However, either they are not offered coverage by their employer or they are unable to afford what is offered. Lack of insurance can lead to significant consequences, not only for the uninsured, but also for the state economy and the health care delivery system. The cost of uncompensated care includes reductions in accessibility and quality as well as higher costs for other consumers. Strategies to reduce the uninsured include raising awareness of AHCCCS programs, especially for children.

Issue #4 – Organizational Capacity

Organizational Capacity is a key component of the agency's strategic plan. To effectively address the challenges related to organizational capacity and to improve management of limited resources, AHCCCS will address both information technology (e.g., system architecture and software) and workforce planning issues (e.g., succession planning for an aging workforce, reduction of turnover, and continuation of a Virtual Office environment). Given an increasing need to do more with less, attention to these issues offers opportunities to serve both the agency and its customers more efficiently.

Strategic Initiatives

Responding to a Growing Aging Population

The time is approaching when the baby boomer generation will turn 65 and create the most dramatic age shift in history. Because of its sheer numbers, this cohort has the potential to place a significant strain on government resources and health system capacities. Arizona (AHCCCS in particular) must plan now for this imminent challenge. The initiative describes the demographic picture, outlines the salient issues and their impact on AHCCCS, and recommends approaches to serving a growing aging population. Recommendations center on coordinating and managing care, ensuring an adequate and appropriate provider network, and considering the impact of demographic aging in all health care preventive efforts and quality improvement processes.

American Indian Health Care

Arizona is home to approximately 277,732 American Indians and Alaska Natives (AI/AN), approximately 44% of whom are enrolled in AHCCCS. Historically, the burden of illness among AI/A has been significantly greater than that of the general population. Thus, in its role as a major source of health care services to this population, AHCCCS is committed to developing strategies that have the potential to positively impact health status. The initiative presents population demographics, identifies major health concerns, explains barriers to the delivery system, and proposes strategies for intervention. Recommendations center on unique health care needs, availability and accessibility of care, data needs and information exchange.

INTRODUCTION: AHCCCS Today and Tomorrow

Vision:
Shaping tomorrow's managed health care… from today's experience, quality and innovation.

Mission:
Reaching across Arizona to provide comprehensive, quality health care for those in need.

Core Values:
Passion, Community, Quality, Respect, Accountability, Innovation, Teamwork and Leadership

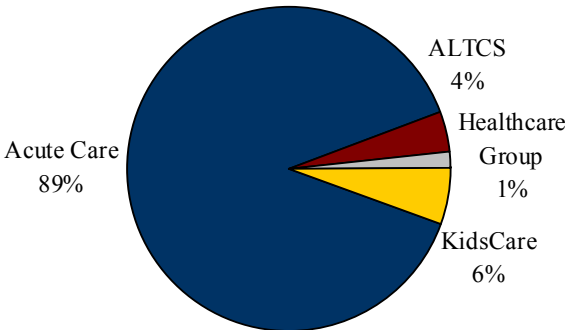
Overview

The Arizona Health Care Cost Containment System (AHCCCS), which serves as the state's Medicaid agency, is a health care program primarily targeted at serving low-income Arizonans. The program is a model public-private collaboration that includes the state and its counties, the federal government, and health plans and providers from both the public and private sectors. In State Fiscal Year (SFY) 2008, AHCCCS provided health care coverage to over 1.1 million Arizonans. The Administration's main responsibilities include setting policy and controls for eligibility determination, member enrollment management, quality assurance of medical care, provider and plan oversight, federal and state financial management and reporting, and procurement of contract providers. AHCCCS uses both a prepaid capitated and fee-for-service (FFS) payment system, but the majority of payment arrangements are prepaid, providing quality health care while managing costs at the same time.

"In SFY 2008, AHCCCS provided health care coverage to over 1.1 million Arizonans…"

AHCCCS has operated under an 1115 Research and Demonstration Waiver since 1982 when it became the first statewide Medicaid managed care system in the nation. The waiver program, which is renewable every five years, was reauthorized this year by the Centers for Medicare and Medicaid Services (CMS). It will not require renewal again until October 1, 2011.

AHCCCS and HCG Enrollment
1,153,740 Members as of Nov 2008

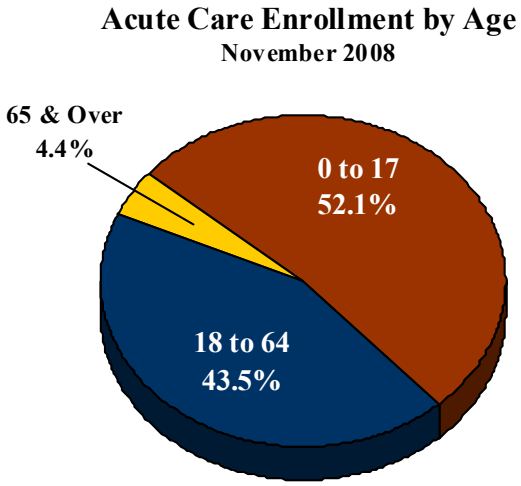


AHCCCS oversees four main programs:

- Acute care services (Acute)
- KidsCare
- Arizona Long Term Care System (ALTCS)
- Healthcare Group (HCG)

Acute Care

As of November 2008, the Acute Care program provides a comprehensive array of health care services to 1,024,763 enrolled members (excluding KidsCare). The majority of the acute care population includes children and pregnant women who are determined eligible for Medicaid (Title XIX). The majority of eligible acute care members receive their care through contracted AHCCCS health plans. American Indians and Alaska Natives who are eligible for acute care services may opt to receive their services through Indian Health Service (IHS) or an AHCCCS contracted health plan. AHCCCS also administers an emergency services program for individuals who, except for their immigration status, would qualify for Medicaid.



KidsCare

The Title XXI State Children's Health Insurance Program (SCHIP), which is referred to as KidsCare, provides affordable insurance coverage for low-income families. Children under the age of 19 may qualify for the program when their family's income exceeds Medicaid income standards, but is below 200% of the Federal Poverty Level (FPL). As of November 2008, 64,754 children were enrolled in KidsCare. With the exception of American Indians, who are exempt from premiums by federal law, parents pay a monthly premium to obtain coverage. The amount of the monthly premium is based on income. The program maximizes federal contributions, realizing a federal contribution of almost $3 for every $1 spent by the state. The upper income limit for program eligibility is 200% of the federal poverty level (FPL). With the exception of American Indian and Alaska Native children, who may elect to receive their care through IHS, children enrolled in KidsCare are assigned to managed-care health plans. Children enrolled in KidsCare receive the same services available to children enrolled with Medicaid.

Long Term Care

The Arizona Long Term Care System (ALTCS) program provides acute care, behavioral health care, long term care and case management services to individuals who are elderly, have a disability, or have a developmental disability, and who are at risk of institutionalization. As of November 2008, 46,923 members were enrolled in the ALTCS program. Whereas these ALTCS members account for only 4% of the AHCCCS population, they account for approximately 27% of the costs. The program emphasizes delivery of care in alternative residential settings. Like the Acute Care program, elderly and physically disabled members of all ages receive their care through contracted ALTCS plans referred to as "program contractors." On-reservation American Indians are enrolled with tribal case management, if available; but, if not, with contracted case

management. Off-reservation American Indians are enrolled with a program contractor, and members with developmental disabilities are served through the Arizona Department of Economic Security (ADES), Division of Developmental Disabilities.

Healthcare Group

Serving Arizona's healthcare needs for more than 20 years, Healthcare Group of Arizona (HCG) is a community-rated health plan that provides healthcare coverage for almost 18,000 members. A mission-driven program, Healthcare Group of Arizona is designed to insure the uninsured and uninsurable small business community. HCG offers businesses with 2 to 50 employees, as well as political subdivisions, both an HMO- and PPO-type plan with multiple benefit options.

Other Programs

In addition to the four main programs previously described, AHCCCS administers a Freedom to Work program and a Breast and Cervical Cancer Treatment program. These are acute care programs and included in previous acute care numbers. AHCCCS also holds contracts with a number of public and private entities that provide a variety of services:

- Behavioral health services, provided by the Arizona Department of Health Services (ADHS), Division of Behavioral Health Services.
- Acute health care services for children in foster care, provided by the Arizona Department of Economic Security (ADES), Comprehensive Medical and Dental Program.
- Services for children with chronic conditions provided through ADHS, Children's Rehabilitative Services (CRS).
- Administrative services such as eligibility determination performed by ADES.
- Claims payments associated with the Medicaid School Based Claiming program that is administered by a private third party administrator.

The Environment: What is AHCCCS Confronting?

To understand the context in which the AHCCCS Strategic Plan was developed, it is important to understand the current environment in which Arizona health care delivery systems operate and the challenges that these systems will face in the future. A host of factors must be considered, including demographic characteristics, state of the economy, and the dynamics of the health care marketplace. These factors are summarized below and within the context of each strategic issue.

Demographic Characteristics of Arizona

Although Arizona is similar to other states in some demographic characteristics (e.g.,

Key Demographics:
One of fastest growing states in the nation
Large Hispanic and American Indian and Alaska Native populations
Uninsured rate exceeds national average

age, gender), it is unique in others (e.g., growth, ethnicity). A variety of demographic factors will impact the way health care services are designed and delivered in Arizona:

- Arizona is ranked second by the U.S. Census Bureau as one of the fastest growing states, following Nevada. The population is expected to increase 108% between 2000 and 2030, to 10.7 million people. Between 2000 and 2006 alone, Arizona growth is estimated to have grown over 20%, compared to a 6% increase nationwide during the same period.
- Arizona has a large Hispanic population (30% v. 15% nationwide) as well as a large American Indian and Alaska Native population (6% vs. 1% nationwide) (U.S. Census Bureau). Both groups also have high rates of uninsured and unemployment.
- The percentage of uninsured in Arizona is 20% compared to 16% nationwide. Hispanics account for 55% of all uninsured non-elderly Arizonans; and, of all non-elderly Hispanics in Arizona, approximately 36% are uninsured (Kaiser, states (2006-2007) U.S. (2007)).
- Arizona is one of four U.S.-Mexico Border states, a fact that contributes to its large population of non-citizens, which is estimated at 11%; among children, 6% are non-citizens (Kaiser).
- The number of Arizonans over age 65 is expected to grow from approximately 790,000 (13% of the population) in 2006 to approximately 1.6 million (18% of the projected population) in 2020. (U.S. Census Bureau; Arizona Department of Economic Security)

Arizona Economy

There is a significant demand for government-supported programs, particularly those that provide health care. Whereas small businesses make a substantial contribution to the availability of low-wage jobs, they frequently fail to offer employer-sponsored insurance and, ultimately, create a greater demand for public programs. Although there is growing concern about the effects this increased demand will have on the General Fund, the amount of federal, state, and local dollars distributed by AHCCCS has some ability to stimulate the economy.

Health Care Marketplace

Recent data indicate that total health care spending represents approximately 16.3% of the Gross Domestic Product (GDP); it is projected to be 19.5% of GDP by 2017. Common factors cited as contributing to increased health care costs include: greater utilization of services; hospital cost inflation; drug costs; acceleration of new medical technologies; and medical liability.

The challenge to meet the demands for medical care is compounded by rising health care costs. The health care inflation rate is expected to increase 6.7% each year through 2017, well above general inflation (2.4%) and growth in the overall economy (4.9%). Overall, the AHCCCS weighted average capitation rate for health plans and program contractors increased 7.3% (8.69% for Acute Care, 2.5% for Long-Term Care).

At the same time, in reaction to a strong national consumer backlash against "managed care," the private health care delivery model has shifted away from health maintenance organizations

(HMOs) to preferred provider organizations (PPOs) that offer consumers greater choice and flexibility. This trend is evident in Arizona, despite the state's history of high HMO penetration. In addition to PPOs, alternative health care benefit models appearing in the market include consumer-driven plans, medical savings accounts, and high-deductible alternatives.

Availability and access to needed medical care is an increasing challenge for the consumer in Arizona. Historically, shortages of health care professionals (particularly specialists) and hospital capacity primarily affected the rural areas of the state. Currently, these shortages are affecting rapidly growing urban areas as well. In short, the volume of medical professionals is not keeping pace with the population growth. In addition, rising malpractice insurance costs have led to changes in physician practices, creating medical coverage issues, excessive emergency department utilization, and a reduction in the number of professionals willing to care for high-risk cases.

Finally, some continuing trends that affect the health care market include:

- An increase in consumers' activism and involvement in the selection of their own treatment and drug preference.
- Changing demographics.
- A decrease in employer-sponsored insurance.
- Challenges to Medicare/Medicaid due to high federal deficits.
- National promotion of e-health.

Growth of AHCCCS

Economic factors and voter-initiated changes in eligibility requirements (e.g., Proposition 204) contributed to the more recent program growth reflected in the figure below, which shows annual changes in the AHCCCS population during the last 20 years. Expansion programs that have extended eligibility limits to 100% of FPL, combined with significant population growth, a proliferation of low-wage jobs, and higher costs for health insurance, have contributed to AHCCCS program growth.

Moreover, these factors have changed the appearance of the AHCCCS population from one comprised primarily of non-working welfare recipients to one including low-wage workers. Coverage of low-wage, uninsured workers reduces illness, increases workplace productivity, and ultimately leads to economic benefits. Affordable health insurance options, as alternatives to publicly subsidized care, are essential to Arizona's economy in the long run. A stable and appropriately financed health care delivery system attracts new business to the state and ultimately benefits everyone.

AHCCCS Strategic Plan

This strategic plan sets forth a new vision for AHCCCS, positioning the agency to more effectively and efficiently meet the health care needs of Arizonans in the twenty-first century.

Introduction

Within the context of the ever-changing health care environment, AHCCCS continues to expand its focus on an integrated, value-driven health care transformation.

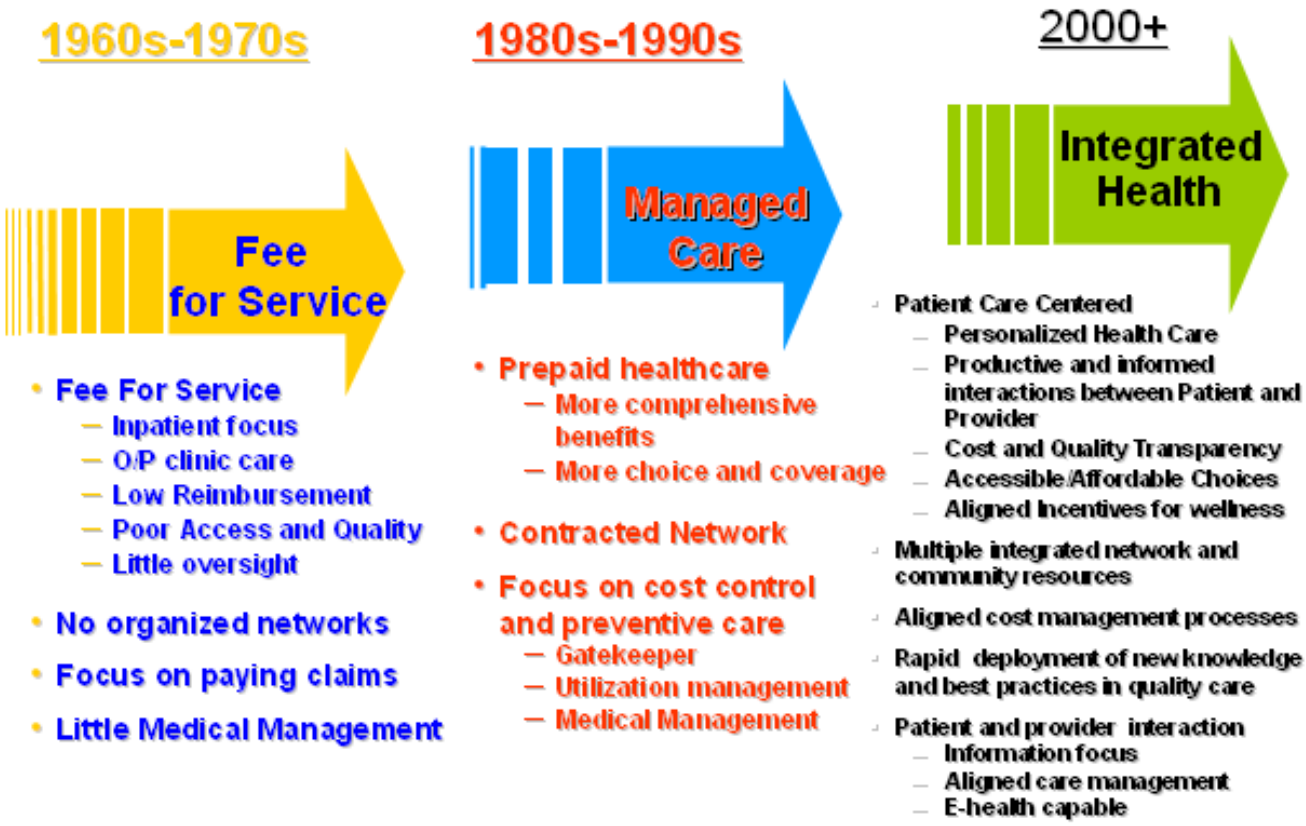
To achieve its movement towards health care transformation, AHCCCS must address four strategic issues:

Strategic Issue #1:	Health Care Costs
Strategic Issue #2:	Health Care Quality
Strategic Issue #3:	The Uninsured
Strategic Issue #4:	Organizational Capacity

Within this document, background information is provided to support the goals and strategies that address each specific issue. It is important to remember that these issues are interdependent. The strategic issues overlap, and effective strategies applied to one issue are often beneficial to another. Because of their interdependence, each strategy builds on the other and each supports the overall plan.

Ultimately, AHCCCS' expectation is that, in addressing each of the strategic issues above in an overarching manner, Arizona will continue to mature in its transformation from managed health care to integrated and value-driven health care, as outlined below.

Managing Health System Transformation in Arizona



Value Driven Health Care

With rising health care costs growing at over 6.7% annually, all Americans are feeling the adverse effects. Employers cannot keep up with these costs and are obligated to pass them on to employees, potentially causing employees to experience net decreases in pay. To help control these costs, health care consumers will need to choose more "valuable" health care (i.e., quality care delivered in an effective and cost efficient manner). Quality care is more than accessibility to services; it is the right care delivered at the right time and in the right setting.

"Every American should have access to a full range of information about the quality and cost of their health care options."

Secretary Mike Leavitt
U.S. Department of Health and Human Services

For consumers to select valuable health care, they need more information about its cost and quality. Currently, health care consumers are making decisions based on anecdotal evidence whereas retail industry prices are published on every shelf. Because of the availability of quality comparison reports (e.g., *Consumer Reports)*, retail shoppers can make decisions in an industry that is transparent. Unfortunately, the availability of comparable healthcare information is limited; and, that which is available, is often difficult to interpret.

To address the limitation of information, President Bush signed executive order #13410 in August 2006 to improve the transparency of America's Health Care System and, ultimately, to empower Americans to find better value and better care (www.whitehouse.gov/news/releases/2006/08/20060822.html). Secretary Mike Leavitt of the U.S. Department of Health and Human Services implemented the President's Executive Order by creation of a "Value Driven Health Care" initiative.

Value Driven Health Care has four interconnected cornerstones:

1. *Interoperable Health Information Technology:* an interconnected system of healthcare information between physicians, hospitals, pharmacies, and other healthcare providers and payers. This interconnectivity will enable the exchange of clinical data, laboratory tests, and radiological images, ultimately resulting in quality of care improvements. Other expected results include reductions in redundant laboratory and radiology procedures as well as decreases in associated healthcare costs.

2. *Transparency of Quality:* accessibility to information on the quality of care.

3. *Transparency of Cost:* accessibility to information on the cost of care.

4. *Incentives for High Value Care:* encouragement to Medicaid beneficiaries to pursue high-value care and incentives for healthcare providers to deliver high-value care.

Secretary Leavitt emphasizes the importance of "Finding the balance between increased access to information and privacy" (www.hhs.gov/news/press/2008pres/1220081215a.html) "If we don't have it, we won't succeed" Secretary Leavitt said.

Value Driven Health Care at AHCCCS

As the largest purchaser of health care services in Arizona, AHCCCS has substantial influence on the state's health system. It is appropriate, therefore, that AHCCCS pursue Value Driven Health Care. Following the direction of President Bush and Secretary Leavitt, AHCCCS' role is to support Value Driven Health Care as a means of improving the health care of AHCCCS members and all Arizonans.

AHCCCS has made significant progress regarding the Value Driven Health Care Initiative. In 2007 AHCCCS was awarded a Medicaid Transformation Grant from the Centers for Medicare and Medicaid Services (CMS) in the amount of 11.8 million to create a state-wide web-based secure Health Information Exchange utility and Electronic Health Record (HieHR) utility. A secure web portal offers providers instant access to electronic health records, addressing the first cornerstone of interoperable health information technology. (See p. 44 for implementation details.)

Quality and cost information will be presented in tandem and at key decision points. Evidence-based medical guidelines will also be included. Other measurements of quality and cost, both for AHCCCS external and internal customers, are currently under development, but will likely include Healthcare Effectiveness Data and Information Set (HEDIS) measures and comparative episode-of-care analytics. Chronic care measures for conditions such as diabetes and asthma will also include rates of emergency room visits, inpatient admissions, and mortality. As laboratory values become available from the HIeHR utility, some quality measures will integrate lab values, such as the percentage of persons with diabetes that decrease HBA1C or maintain low levels. Essential for the evaluation of clinical data is risk adjustment to compensate for a member's overall risk due to past medical history and demographic factors.

Finally, AHCCCS has submitted plans for physicians' incentives around diabetes care and immunizations for children age two for approval by the state legislature. Other incentives may be proposed at a future date.

For further reading on Value Driven Health Care, please see the following:

http://www.hhs.gov/valuedriven/
http://www.whitehouse.gov/news/releases/2006/08/20060822.html
http://www.deloitte.com/dtt/cda/doc/content/us_chs_pricetransparency_031307.pdf
http://www.leapfroggroup.org/media/file/A_Guide_for_State_Medicaid_Agencies_5.9.07.pdf
http://www.hrsa.gov/medicaid/SMDL07005.htm
http://www.commonwealthfund.org/

STRATEGIC ISSUE #1: Health Care Costs

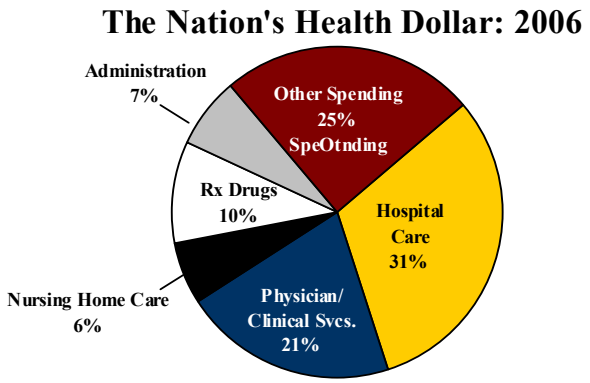
National health care costs continue to grow faster than national income, and health spending continues to increase faster than the overall economy (i.e., Gross Domestic Product, or GDP). As a share of the economy, health care has risen from 7.2% of GDP in 1965 to over 16.3% of GDP currently. It is projected to be 19.5% of GDP by 2017. In February 2008, prior to the dramatic downturn in the global economy, the CMS Office of the Actuary stated that the national health care inflation rate is expected to increase 6.7% each year through 2017, well above general inflation (2.4%) and growth in the overall economy (4.9%). Medicaid dollars represent a significant percentage of federal spending and place a major strain on the federal budget. As a result, Medicaid is increasingly more vulnerable to federal cost-cutting strategies. Arizona's population has increased significantly over the past several years and is expected to continue to outpace its current rate of growth. Subsequently, this may increase membership in the AHCCCS program. Although AHCCCS growth promotes spending that ultimately benefits the health sector economy, this growth must be balanced with its impact on the state General Fund.

"…the national health care inflation rate is expected to increase 6.7% each year through 2017, well above general inflation (2.4%) and growth in the overall economy (4.9%)."

Environmental Scan

Health Care Cost Drivers

The growth rate of national health care spending continues to increase above that of the overall economy. According to CMS, U.S. health care spending rose 6.7% to $2.1 trillion in 2006 or approximately $7,026 per person. Future spending projections suggest little change to this pattern. The high rate of growth in health care expenditures can be attributed to a number of key cost drivers including general price inflation, provider supply and



Note: Other spending includes dental services, other professional services, home health care, durable medical equipment, over-the-counter medication, public health services, research, and construction.

Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.

market structure, provider operating costs, health status of the population, changes in treatment patterns and technology. The Center for Studying Health System Change reported some interesting trends in health care spending:

- Hospital Spending: Hospital spending accounts for nearly one-third of total health care spending and the largest share of national health expenditures. Hospital spending grew 7.0% in 2006. This rate of growth is slightly lower than 7.9% of the previous year and likely driven by lower utilization of hospital services, particularly within Medicare, as fee-for-service inpatient hospital admissions declined.
- Prescription Drugs: Prescription drug spending accelerated for the first time in 6 years, from a low of 5.8% in 2005 to 8.5% in 2006. Approximately one half of this growth was due to an increase in the use of prescription drugs (in part, a result of Part D coverage). Other contributing factors included new indications for existing drugs, growth in therapeutic classes, and increases in the use of specialty drugs.
- Physician Care and Clinical Services: 2006 spending on physician and clinical services represented the slowest rate of growth since 1999. This slowdown was driven by a near freeze on Medicare physician payments which fueled a deceleration in price growth.

Medical Expenditures

Nationwide

The Kaiser Commission on Medicaid and the Uninsured and Health Management Associates conduct an annual survey of Medicaid officials in all 50 states and the District of Columbia. Most recent indications show that total Medicaid spending grew by 5.3% in FY 2008. The survey also found that more states made restorations, enhancements, or expansions to their Medicaid programs than made cuts for fiscal years 2008 and 2009. It should be noted, however, that much of the data collection was conducted at the beginning of 2008, when the economy was stronger, allowing states to implement a variety of Medicaid improvements and expansions. Thus, Kaiser points out that the survey likely understates the eventual effect of the poor economy on Medicaid.

One Kaiser analysis indicates that, for every 1% increase in national unemployment, Medicaid and SCHIP enrollment also increases by one million, combined state and federal Medicaid spending increases by $3.4 billion, and the uninsured population increases by 1.1 million since many people who lose employer-sponsored coverage do not qualify for Medicaid.

Arizona

Arizona, like the rest of the nation, continues to experience growth in overall program expenditures. In SFY 2008, AHCCCS overall program expenditures (Acute Care, Long Term Care, KidsCare) grew 11.94% over SFY 2007. Program expenditures are affected by a variety of factors including:

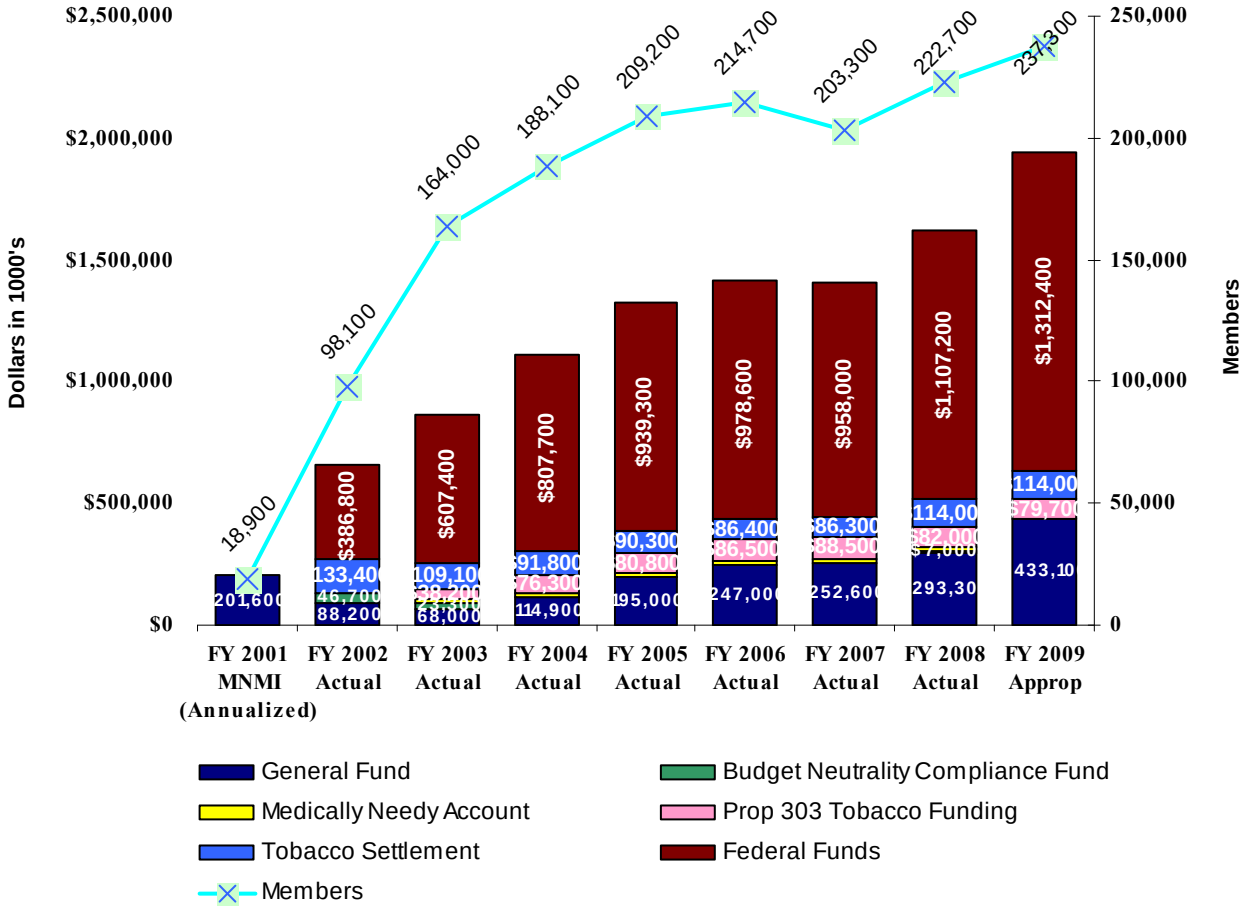
- Utilization: Capitation rates are designed to maintain the financial viability of contracted health plans and to reflect utilization and care management. Increases in utilization have a significant impact on capitation rates.

- Long Term Care: Whereas ALTCS members accounted for only 4% of the nearly one million AHCCCS enrollees, they accounted for a disproportionate 27% of total AHCCCS expenditures. As the elderly population increases, AHCCCS faces greater challenges to develop innovative and effective programs that offer quality and cost-effective services.
- Provider Payments: The costs of AHCCCS physician and inpatient hospital services continue to increase. As a result, Contract Year 2009 capitation rates reveal a weighted average increase of 7.3% (8.69% for Acute Care and 2.5% for Long Term Care).

Despite increases in general health care costs, AHCCCS continues to seek creative opportunities to cover the uninsured. Specifically, two programs that make use of non-state funds exemplify these efforts.

Proposition 204: In late 2000, a voter initiative expanded Medicaid eligibility to 100% of the FPL. Prior to implementation of this proposition, most childless couples or single adults earning more than 35% of FPL did not qualify for AHCCCS. Many of these individuals were covered through county or state-only funds. Others received services for which the providers, such as hospitals and physicians, were not compensated. These types of unpaid costs are often passed on to consumers through cost shifting, where losses are balanced by higher premiums for commercial healthcare coverage and higher rates for healthcare services.

SFY 2001 MN/MI Expenditures vs. SFY 2002 - SFY 2009 Proposition 204

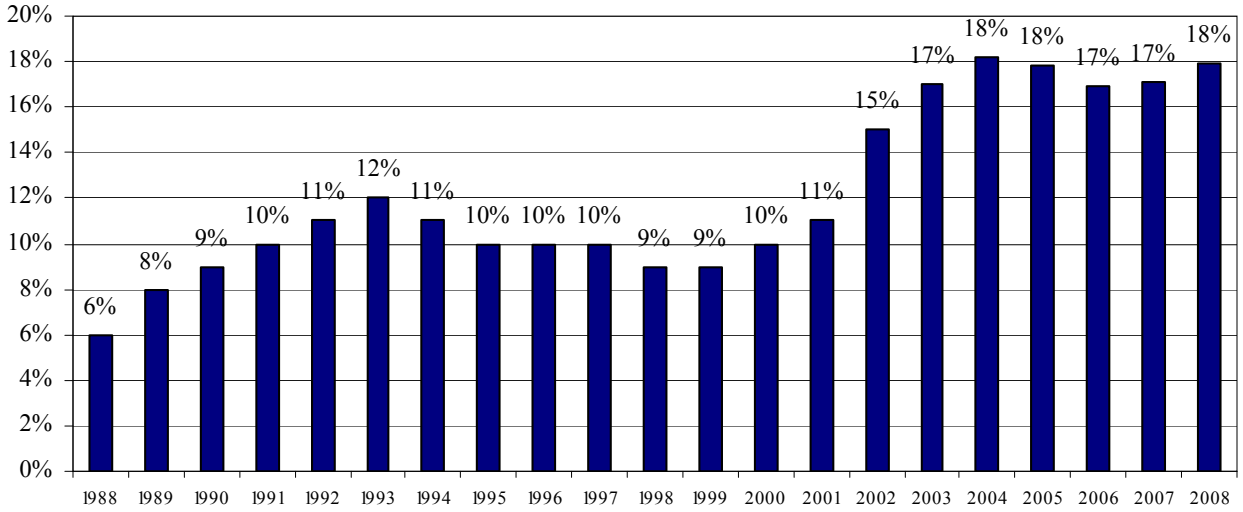


As a result of the implementation of Proposition 204, a number of programs, supported solely by state and county funds, were eliminated. New Medicaid eligibility categories were created, replacing previous state and county funded programs such as those for the Medically Needy (MN) population which qualified for coverage based on catastrophic medical events. Although relatively small, these populations were very costly to the state.

Implementation of Proposition 204 permitted Arizona to claim federal matching funds for populations previously covered by state and county funds only. New Medicaid categories for single adults and childless couples were created. As a result of these changes, Arizona has been able to expand coverage to uninsured Arizona adults, without requiring a significantly greater portion of the general fund. It is important to recognize this benefit as budget constraints prompt the state to consider program cutbacks. If Proposition 204 had not been implemented—or if it is repealed—Arizona would still assume significant responsibility for this growing and costly population, albeit without the aid of federal Medicaid funds.

The figure above illustrates the number of individuals covered by the former MN/MI program and the state dollars required to fund this group in SFY 2001. For subsequent years, the figure illustrates how additional funding sources, such as tobacco settlement and tobacco tax revenues, as well as federal Medicaid funds, have been leveraged to cover a larger population (237,300 in SFY 2009 versus 18,900 in SFY 2001).

PERCENT OF ARIZONANS ON AHCCCS



Data does not include Healthcare Group or Medicare Cost Sharing populations

Employer Sponsored Insurance (ESI): As required by the Health Insurance Flexibility Act (HIFA) 1115 Waiver, Arizona began implementation of an Employer Sponsored Insurance (ESI) program on December 1, 2008. AHCCCS subsidizes health insurance premiums for SCHIP-eligible children with household incomes between 100% and 200% of FPL who have the option of receiving health insurance coverage through their employers. ESI allows subsidized payments

to be made on behalf of SCHIP-eligible children for their portion of their health care premium. Employers are expected to pay a percentage of the premiums for dependent coverage.

In other states, where similar programs have been implemented, families indicate that they prefer to receive coverage through their employer's insurer to avoid the stigma of public coverage. The advantage of this type of arrangement is that a significant portion of Arizona's Medicaid matching funds will be paid by the employer rather than through SCHIP funds.

It is important to note that continued renewal by the Arizona Legislature of the AHCCCS HIFA program is necessary for the implementation of an ESI program. Renewal of the HIFA Parents program is also important in that it provides premium-based coverage for the working parents of KidsCare or Medicaid-enrolled children at a higher federal matching rate. Further, it offers insurance to a population that typically cannot afford coverage or does not have coverage available through an employer.

The HIFA Parents Program
Decreases the number of uninsured in Arizona.
Decreases the state cost in general funds for some populations.
Increases program savings by sharing healthcare coverage costs with employers.

Significance to AHCCCS

As enrollment growth and health care costs continue to increase, AHCCCS expenditures are expected to consume an increasing portion of the state General Fund. However, future allocations are dependent upon appropriated state tax revenues and federal funding in a current climate of recession and obvious resource concerns. It is expected that enrollment demands placed on AHCCCS will increase as unemployment and underemployment trends continue. Thus, it is imperative that AHCCCS continue to focus on cost control strategies that can effectively manage this growth. This is particularly important because future demands on the state General Fund will be compounded by several factors:

- Reductions in Federal Fiscal Relief: Since 2004, when Congress did not extend the federal fiscal relief that was provided to states to meet budget shortfalls, General Funds have been compensating for the consistent annual decreases in federal funding.
- Decreased employer-based health care coverage: Continued pressure by diminishing employer-based coverage and increasing low-wage employment increases the need for Medicaid services.

By controlling the growth in expenditures, AHCCCS can help conserve state funds for other critical state services such as education and public safety. An ongoing challenge for AHCCCS will be to develop cost control strategies that (1) will not ultimately end up increasing costs (e.g., restricting the number of prescriptions per month can lead to increased hospitalizations), or (2) will not interfere with efforts to reduce the number of uninsured. (See Total Resources and Assumptions.)

STRATEGIC ISSUE #1:
Health Care Costs

GOAL: Maintain average annual capitation rate (per member per month) increases at or below 6%.

AHCCCS STRATEGIES:

- Continue efforts toward more equitable and manageable provider rate structures and payment methodologies.
- Continue to explore cost-effective purchasing options for key Medicaid services.
- Maximize use of non-state funding sources (e.g., grants).
- Establish and monitor health plan quality and cost benchmarks to ensure efficient cost-effective health plan operations.
- Continue to work with CMS to implement Congressional Budget Reconciliation bills and support Medicaid legislative changes to reduce program costs.
- Use Executive Utilization Management reports for ongoing health plan comparison and benchmarking.

PERFORMANCE MEASURES:

- Average percent change in capitation rates (overall per member per month)
- Eligibility error rates
- Percent of AHCCCS funding attributable to non-state funding sources
- Cost savings/cost avoidance from implemented strategies

RESOURCE ASSUMPTIONS

Dollars are shown in thousands:

Strategic Issue # 1	SFY10
FTE	-
General Funds	-
Other Appropriated Funds	-
Non-Appropriated Funds	-
Federal Funds	-
Total Funds	**$0.00**

Notes:

(1) The only Resource Assumptions included as part of this strategic issue are those that represent either new program services or administrative additions to existing programs. These are included within the agency's annual Budget Request as critical issues or decision packages.

(2) Future fiscal years are not shown as the agency is required to submit budget requests annually.

Cost Assumptions:
No additional strategic resources are included in the SFY 2010 Budget Request to facilitate this Strategic Issue.

STRATEGIC ISSUE #2:
Health Care Quality and Access to Care

Quality health care is multi-faceted, encompassing a vast array of criteria that result in receiving the correct treatment in the right setting at the right time. It blends both the science of health care and the personal aspects of receiving care in a culturally-respectful manner by ensuring that care is tailored to meet the needs of individuals. Quality health care includes both disease management and the prevention of illness, and results in fewer medical complications, better outcomes, and lower costs. Access and availability are key factors in ensuring the delivery of quality health care. Inability to access care may result in delayed treatment and treatment in inappropriate settings, leading to poorer health outcomes and increased costs. Quality health care, and access and availability to care, are addressed separately in the following text. However, it is important to keep in mind that access to care is a key component of delivering quality health care; therefore, the two issues are not mutually exclusive.

"Quality health care . . . results in fewer medical complications, better outcomes, and lower costs."

A. Quality Health Care

Environmental Scan

Health Status

Following are key health status characteristics of specific populations within the United States, Arizona, and the Medicaid population. The 2007 United Health Foundation's composition index of states ranked Arizona 33rd in the nation in terms of its overall health status, considering both risk factors (e.g., violent crime and lack of health insurance) and health outcome measures (e.g., mortality and disease prevalence). This ranking has clearly eroded, as evidenced by the 2004 ranking of 23rd in the nation. Although improvements have been made and are encouraging, the state continues to face a number of challenges. In general, the Medicaid population tends to have poorer health status than the non-Medicaid population. As a result, some of the statistics presented below may be even higher when applied to Arizona's Medicaid population. In addition, given Arizona's culturally diverse population, it is important to note that ethnic disparities exist within each of these key populations.

Children

The Annie E. Casey Foundation's *2008 Kids Count Data Book* ranked Arizona 39th in the overall well-being of its children, down from 36th just last year. This ranking was based on factors such as mortality, family composition, adequacy of income, and educational attainment.

Births:

- According to the National Center for Health Statistics, the latest data available (Final 2005) shows Arizona's teen (ages 15-19) birth rate is higher than the national average (58.2 per 1,000 births compared to 40.5 per 1,000 births nationally). Arizona ranks 5th nationally in this regard.
- Arizona also has a higher rate of total births (among mothers of all ages) than the national average (16.2 per 1,000 births compared to 14.0 per 1,000 births nationally) and is ranked the 3rd highest in the nation, behind Utah (20.9) and Texas (16.9).
- AHCCCS covers the costs of 52% of the state's births.
- The rate of low and very low birth weight and pre-term infants tends to be significantly higher among blacks in Arizona and nationally.

Chronic Illness:

- CDC statistics show that in 2005, 22.2 million Americans currently were diagnosed with asthma; 32.6 million had been diagnosed with asthma during their lifetimes; and 12.2 million experienced an asthma attack in the previous year. Of those currently diagnosed with asthma, approximately 600,000 (3%) are Arizonans. Consistent with the nation-wide average, 8% of Arizona children currently suffer from asthma.
- The National Health and Nutrition Examination Survey is a standardized survey instrument that has been used since the mid 1960s to measure the prevalence of overweight and obesity among children. The most recent survey (2003-2004) indicates that an estimated 17% of children and adolescents ages 2-19 years are overweight. Moreover, it shows that overweight increased from 7.2% to 13.9% among 2-5 year olds, from 11% to 19% among 6-11 year olds, and from 11%-17% among adolescents ages 12-19. Children who are overweight are at an increased risk of developing type two diabetes, cardiovascular problems, orthopedic abnormalities, arthritis, and skin problems.
- Pediatricians are disturbed by the rapidly increasing trend of Type II diabetes in children. Previously, this form of diabetes was associated specifically with older adults.
- Dental disease, the most prevalent chronic disease of childhood, affects children's overall health and ability to succeed. Dental caries (tooth decay) is an infectious disease that is particularly widespread among the indigent and minorities. It is five times more common than asthma and it is estimated that 80% of the disease occurs in 20% of the population. Typically, the populations with the highest incidence of this largely preventable disease are low-income and minority children.

Adults

Chronic Illness:

- Chronic conditions are the leading cause of death and disability nationwide, affecting over 45% of the population (including 117 million adults). They are responsible for over two-thirds of all deaths and account for approximately 78% of health care spending. In fact, between 2000 and 2030, the number of Americans with chronic conditions is expected to

increase by 37%. It is disturbing, therefore, that, although chronic conditions are the most prevalent and costly of all health problems, they are also the most preventable.

- Consistent with nationwide statistics, chronic disease accounts for seven of the 10 leading causes of death in the state of Arizona (Arizona Health Status & Vital Statistics, 2004).
- A snapshot of those with chronic conditions reveals that: (1) Chronic conditions affect women disproportionately - 80% of women aged 65 to 85 report at least one chronic condition compared to 33% of men in that age group; (2) Half of all people with chronic conditions have multiple chronic conditions; (3) Among people over 65, hypertension is the most common chronic condition; and (4) Among those 18 to 64, chronic mental conditions are the most common.
- Diabetes is expected to place a significant burden on Arizona's health care delivery systems in the next decade. As reported in the most recent *Diabetes in Arizona Status Report (November 2005)* 6.6% of the adult population has been diagnosed with diabetes. Hospitalization rates related to the disease are rising, and the average hospital stay for an individual with diabetes costs over $26,000. Certain populations such as American Indians and Alaska Natives as well as Hispanics have higher incidences of Type II diabetes than the general population. According to vital statistics, the overall statewide ratio of deaths from diabetes in 2005 was approximately 20.1 per 100,000 population. The ratio for Arizona American Indians and Alaska Natives was 69.9 per 100,000 population (an increase from 55.8 per 100,000 in 2003).
- According to a 2007 report published by the Arizona Department of Health Services and based on the ongoing Arizona Behavioral Risk Factor Surveillance System survey as well as the hospital discharge database and mortality data, the prevalence of obesity rate in 2006 was 22.9%. This means that, over the past 15 years, the estimated prevalence of obesity in Arizona's adult population more than doubled.
- On a more positive note, heart disease rates in Arizona have been decreasing.

Men's Health:

- A leading cause of death among men is heart disease, followed by cancer. Fortunately, the risks associated with both can be reduced with changes in lifestyle.
- Lung cancer is the most common type of cancer responsible for male deaths. Ninety percent of lung cancers result from smoking cigarettes.
- Approximately one in six men in the United States will be diagnosed with prostate cancer during their lifetime. In Arizona, prostate cancer is the most commonly diagnosed cancer and the 3rd leading cause of death in men. A total of 3,610 new cases from this disease are estimated for 2008.

Women's Health:

- In Arizona, the percentage of pregnant women receiving prenatal care in the first trimester has increased slightly over the past several years to 78% which, according to Kaiser, is consistent with the national percentage.

- Women are more likely than men to have chronic conditions. In part, this is because women typically live longer than men.
- The percent of women reporting poor mental health is higher than that of men.
- The American Cancer Society estimated that approximately 3,220 new cases of breast cancer will be diagnosed among women in Arizona in 2008, with disproportionately higher rates among the black population.

Health Status Concerns and Economic Impact

Consequences of the Lack of Quality Care

Increased Costs: Lack of quality care leads to additional hospitalizations and increased health care costs. Nationally, quality problems are thought to account for up to 81,000 preventable deaths a year and billions of dollars in avoidable hospital costs and lost productivity. Research, conducted by the National Committee for Quality Assurance (NCQA), demonstrated that the lack of care for four common conditions (asthma, depression, diabetes, and hypertension) accounted for an annual loss of 64.7 million working days in productivity, costing an approximate $10.6 billion.

Reduced Quality of Life: Individuals living with chronic conditions are challenged physically, emotionally, and financially. The public's three greatest fears related to chronic conditions are: (1) Inability to pay for care, (2) Loss of independence, and (3) Becoming a burden to family and friends.

Factors Contributing to Poor Health Status

A major concern is that obesity is often the precursor to diseases such as diabetes, coronary heart disease, arthritis, or stroke. To the extent that lifestyle choices factor into the development of chronic disease, wellness programs to reduce smoking, decrease substance abuse, and control weight through diet and exercise can reduce future costs related to the chronic care burden.

Aging: As the percentage of Arizonans over the age of 65 increases, there will be more individuals with disabilities and multiple chronic conditions requiring long term care. This fact is of particular concern given current findings indicating that individuals enrolled in the long term care program account for only 4% of the AHCCCS population but 27% of AHCCCS expenditures.

Factors for Consideration in Strategy Development

Coordination of Care: Nearly half of all people with chronic conditions have multiple chronic conditions and three or more different physicians. Coordinating care for individuals with multiple chronic conditions can be challenging, particularly given the added complexities of the Medicare Modernization Act (MMA) and its related drug benefit programs. Often times, people with multiple chronic conditions report receiving inadequate information from their providers. Others may fail to receive information about potentially incompatible drugs. Still others may

undergo duplicate tests or procedures. Coordination between disciplines is a vital ingredient of quality care. Coordination failures can be both costly and dangerous.

Ethnic Disparities: Cultural competence and consideration of ethnic disparities impact quality of care, particularly in Arizona, with its diverse population. In particular, language barriers may cause difficulties in communicating important information and instructions to patients, increasing the risk of error. The latest survey of AHCCCS members indicated that between 12% and 14% of respondents had some problems communicating with their medical provider. Approximately 8% reported needing an interpreter. Studies show that communication is a key factor in the development of trust. Further, when patients trust their medical providers, compliance improves.

Improving Quality of Care

Prevention and Wellness

Prevention and wellness services are among the most cost-effective. These services include immunizations, prenatal care, wellness programs, health education, and age-appropriate health screenings and immunizations. Although these programs are established for prevention, they also allow for early identification and treatment of disease.

Medical Management

Disease Management/Chronic Care Models: Disease management programs employ stratified interventions based on patient health status and risk. Often, disease management programs focus on patients with high risk and/or chronic conditions that have the potential to benefit from concerted intervention (e.g., diabetes, asthma, cardiovascular disease, HIV/AIDS). Chronic care program models assist individuals in managing their own care. In general, disease management programs are associated with more effective practice patterns, improved quality of care, and lower costs.

Diabetes serves as a good example of the potential value of disease management. As an example, a study published in the Annals of Internal Medicine, found that health care providers' use of management programs resulted in higher rates among their patients of recommended examination, such as eye and foot exams, testing for kidney function or damage resulting from diabetes, cholesterol checks, and getting vaccinations.

Case Management and Care Coordination: Case management applies to individuals with catastrophic, chronic, or multiple conditions that consume a disproportionate share of an organization's health care dollars. It typically includes individualized patient education, care coordination, and assistance with navigation through the health care system. Although case management efforts are often part of an organization's disease management program, they may also be extended to control high utilizers and difficult-to-manage individuals who are not in dedicated disease management programs.

Evidence-Based Treatment Guidelines and Best Practices

Basing medical management decisions on evidence-based treatment guidelines and best practices is an effective means of managing costs and improving quality. Specific practice guidelines that identify treatment protocols for various conditions can reduce treatment disparities and improve outcomes. These protocols have been developed with both outcomes and cost efficiency in mind. Effective practice guidelines, commonly used in disease management programs, may lead to reduced inpatient and emergency room utilization and changes in patient care patterns.

Oral Health

The Centers for Disease Control and Prevention reports that dental caries (tooth decay) is perhaps the most prevalent of infectious diseases in our nation's children. Oral disease affects children's overall health and ability to succeed. More than 40% of children have caries by the time they reach kindergarten. Early childhood caries (ECC) can be a particularly virulent form of caries, beginning soon after tooth eruption. Caries is a disease that is transmissible but is also, by and large, preventable.

It is imperative that Arizona and AHCCCS focus available resources on all aspects of caries prevention. Collaborative efforts between AHCCCS and contracted health plans have proven to be successful and should be continued (see: Accomplishments, p. 60). New strategies such as a high level of involvement of primary care physicians in children's oral health and oral disease prevention should be encouraged. Health care professionals and other stakeholders in children's health should support the identification of a dental home by 12 months of age.

Centers of Excellence

Centers of excellence focus on particular disease episodes related to high-cost, high-volume conditions. They consist of a network of hospitals, physicians and other providers who integrate care to achieve both quality outcomes and cost efficiencies. Physicians and facilities having obtained a degree of excellence in their areas of expertise may be certified through such national organizations as the American Academy of surgeons. Examples of centers of excellence include those dedicated to cardiac care, diabetes management, organ and tissue transplantation, burns, and cancer treatment.

Pay-for-Performance and Provider Recognition Programs

One of the four cornerstones of the Value Driven Healthcare System promoted by CMS is the use of incentives aimed at improving delivery of appropriate care and avoiding costly errors. Provider performance programs vary from national government-sponsored efforts to health plan-specific initiatives. Currently, multiple health plans offer pay-for-performance (P4P) compensation to physicians nationwide. This number is expected to increase significantly. P4P programs have met with varying degrees of acceptance by physicians and other providers, depending greatly on both the methodology of the P4P program and the perceived aims of those programs. AHCCCS is reviewing various options for a P4P program that meets with provider acceptance and promotes improvements in the health care delivery.

In addition, a P4P program for nursing home providers is also under consideration. This program would provide an additional lump sum payment to the top 40% of nursing facilities that

have the lowest incidence of preventable pressure ulcers on their residents. Legislative approval is necessary before either P4P program can be initiated.

Enhanced Member Education and Cultural Sensitivity

Studies show that knowledgeable and informed managed care members have greater compliance and healthier behaviors. Strategies to enhance member education may include activities such as the use of multi-language videos to explain the managed care system as well as how to establish routine care through a primary care physician, access qualified interpreters to communicate medical information, and appropriately use an emergency department. The effective use of telecommunications and internet technology can improve patient communication and understanding of the importance of prevention and lifestyle changes, ultimately resulting in reduced costs.

Member and Provider Satisfaction

Research indicates that satisfaction of both members and providers is an important factor in an effective managed care delivery system. Provider dissatisfaction has been linked to poor clinical judgment, disruption in continuity of care, and patient dissatisfaction. Failure to address such issues may lead to a loss of quality physicians, the need to increase rates to the remaining network, and access to care issues. Member dissatisfaction may be linked to such behaviors as "no-shows," non-compliance with treatment, and alternative use of emergency departments. Failure to address such issues may lead to inadequate care and, ultimately, higher costs. Conducting both member and provider satisfaction surveys, and using the findings to inform quality improvement activities is an important step toward ensuring ongoing quality of care.

Significance to AHCCCS

It is critical that AHCCCS members receive quality services from AHCCCS health plans. Maintaining a high level of quality facilitates the effective use of state and federal dollars, and may ultimately lead to a healthier and more productive Arizona population. To ensure that they are providing quality services to members, AHCCCS health plans are monitored on a selection of performance measures that are part of the Healthcare Effectiveness Data and Information Set (HEDIS) established by the National Committee for Quality Assurance (NCQA). HEDIS is the most widely used methodology for measuring preventive and other health care services, having been adapted and adopted by Medicaid, Medicare, and commercial health plans nationwide. In addition, AHCCCS uses a variety of other performance measures to gauge the quality of services provided to members.

B. Access to Care

Environmental Scan

Availability and Accessibility of Providers

Number and Distribution of Physicians

Arizona's rapid population growth is placing significant pressure on the current health care infrastructure and its health care facilities, making it more difficult for the state to accommodate the needs of a growing population. The state is facing shortages of both professional staff as well as hospital beds. Reports indicate that the ratio of Arizona physicians to population remains well below the nationwide ratio. The ratio of hospital beds in Arizona is 2.0 per 1,000 people vs. a nationwide ratio of 2.9 per 1,000 people. Furthermore, the distribution of providers in urban versus rural areas is disproportionately in favor of urban areas.

A variety of barriers and concerns interfere with the recruitment and retention of providers in Arizona:

- Rising malpractice costs
- Extended work hours due to limited networks and shortages of providers
- A high rate of uninsured individuals
- Reductions in provider reimbursement

Based on survey results, the Harris Management Group concluded that the issues of greatest concern to Maricopa County Physicians were:

- Reimbursement
- Malpractice Insurance Costs
- Operating Expenses
- Regulation

Additional data collected from respondents indicated that:

- 25% reported a decrease in time spent with each patient
- 40% reported a decrease in income
- 62% reported less enjoyment from practicing medicine
- 50% believed that the cost of malpractice insurance adversely impacted access to care and overall quality

Geographical Concerns

A total of 6,033 areas in the United States were designated as Primary Medical Health Professional Shortage Areas (HPSA) as of September 30, 2008. Of these, 68% are in non-metropolitan areas.

Health Professional Shortage Areas (HPSA) in Arizona

		Primary Care	Dental	Mental Health
US standard for population-to-practitioner ratios		2,000:1	3,000:1	10,000:1
Estimated Underserved Population in Arizona		1,045,104	467,450	889,819
Number of practitioners needed to:	Remove HPSA Designation	291	98	56
	Achieve US standard for population-to-practitioner ratios	488	134	84

Source: HRSA Information Center, Shortage Designation Branch; Health Professional Shortage Areas, Tables 2-5, dated as of September 30, 2008.

Further, the U.S. Health Resources and Services Administration (HRSA) defines Medically Underserved Areas/Populations (MUA/MUP) as a whole county or a group of contiguous counties, a group of county or civil divisions or a group of urban census tracts in which residents have a shortage of personal health services; and MUPs may include groups of persons who face economic, cultural or linguistic barriers to health care. Arizona is home to a number of these areas. According to HRSA, 43 areas in Arizona currently have federal MUA/MUP designations. Generally, these are rural areas. Persons living in these designated areas:

- Are more likely to be uninsured than urban residents.
- Generally tend to be poorer and less healthy than those in urban areas.
- Have more difficulty obtaining necessary health care services because the number of providers is limited, as is availability.
- Have difficulty obtaining transportation to receive necessary care. Specifically, necessary specialty care may require extensive travel.
- Have fewer choices for health insurance coverage because the HMO penetration rate in rural areas is lower than in urban areas. In addition, employer-sponsored insurance is less widely available in rural areas due to the proliferation of small businesses that are less likely to offer employee health insurance.

Additional Factors for Consideration in Strategy Development

Coverage Options and Choice of Providers in Rural Areas: Health plans (both HMOs and PPOs) may avoid rural areas because of a lack of providers as well as consumers. When they do decide to offer coverage in rural areas, network development can prove difficult, particularly in view of Arizona's current shortage of medical professionals and hospital beds. The lack of competition in these areas may also drive up health care costs.

Inappropriate Use of Emergency Rooms: When provider networks are inadequate and/or residents are uninsured, emergency departments provide a costly alternative to primary care.

Transportation Services: The provision of medically-necessary transportation (including EMS) is an ongoing challenge that affects cost as well as accessibility to care.

Lack of Care and Delayed Care: It is generally accepted that a lack of access to care or lack of timely access to care may be linked to poor health outcomes. Approximately 46% of insured and 57% of uninsured individuals with chronic conditions report problems accessing care. Individuals with serious chronic conditions also report difficulty accessing specialty services.

Ethnic Disparities: The Commonwealth Fund reports that "Hispanics are more likely than any other group in the U.S. to be uninsured and have difficulty obtaining access to health care – this problem is made worse by language barriers." These concerns are significant for Arizona and AHCCCS, both with substantial Hispanic populations.

Strain on Providers: Because Arizona has a lower provider/population ratio than the national average, Arizona providers, including dental providers, work harder to fulfill the demand for health care. Many report working longer hours, receiving less reimbursement, and compromising quality of life.

Tribal Consultation: The involvement of Arizona Indian tribes in the development of policy or programmatic changes that directly affect tribes allows for locally-relevant and culturally-appropriate approaches to important issues.

Approaches to Improving Access to Care

Safety Net Providers

Safety net providers, such as Community Health Centers, are an important source of care for Medicaid beneficiaries and for the uninsured. In Arizona, 75% of all community health center patients are either uninsured or enrolled in AHCCCS. Approximately 35 non-profit, community-based primary care organizations across the state account for over 140 service sites (including clinics, satellites, and school-based programs).

Improving Availability of Care

Development of alternative locations for non-emergency care and extended hours can be an important approach to ensuring that members do not seek care in more costly inappropriate settings. Development efforts may be in collaboration with a variety of stakeholders (e.g., community health centers).

Telemedicine

Telemedicine programs offer valuable opportunities for improved accessibility to health care in both rural and metropolitan communities. The Arizona Telemedicine Program provides 153 telemedicine services throughout much of Arizona, including 69 hospital/clinic sites, 49 behavioral health sites, 22 correctional facility sites, 3 school sites, and 6 health sciences education and research sites. In addition, AHCCCS supports the Community Health Center/Office of Rural Health Collaboration to expand telemedicine services and develop payment policies that stimulate their use. The AHCCCS American Indian Health Program has collaborated with the Indian Health Service and tribally-operated facilities operating under Public Law 93-638 to advance the implementation of telemedicine services across Arizona to serve American Indians and Alaska Natives enrolled in the AHCCCS program.

Graduate Medical Education (GME)

GME includes required internships, residencies, and fellowships a physician must complete following graduation from medical school as part of the physician licensing process. Following payments by patients and Medicare, Medicaid is the next largest explicit payer of GME, estimated at nearly $3.2 billion nationally in 2005, comprising about 7% of total Medicaid inpatient hospital expenditures. States are not obligated to pay for GME, but it has long been recognized that Medicaid funding is critical to ensuring that there are physicians available to treat Medicaid patients in a hospital setting. As a result, Medicaid programs in 47 states and the District of Columbia make explicit payments to teaching hospitals to subsidize GME costs.

There is no explicit authority for Medicaid funds to pay for direct GME costs (resident salaries, faculty stipends, and program administrative costs); however, state Medicaid GME payments have been matched by the federal government at each state's usual Medicaid matching rate since Medicaid's beginnings. Payments for indirect GME costs (increased hospital operating costs resulting from teaching activities) are expressly authorized.

In his Fiscal Year 2008 budget proposal, President Bush proposed to end federal Medicaid funding for direct GME costs, estimating savings to be $140 million in FY2008 and $1.780 billion from FY2008-FY2012. This move would not affect payments for indirect GME costs. In May 2007, the Centers for Medicare and Medicaid Services published proposed rules implementing the President's proposal. Congress placed a one-year moratorium on the implementation of the proposed rules to give the subject time for further study.

Researchers at the Arizona State University and the University of Arizona found that Arizona employs 20.7 physicians per 10,000 people, which is already substantially below the national average of 28.3 per 10,000 people. If Medicaid GME funds are eliminated, it is expected that Arizona's ability to attract and sustain medical residency positions would quickly deteriorate.

Since the site of residency training is a major influence on a physician's choice of a location to practice, graduate medical education programs offer the potential to improve recruitment and retention of providers throughout the state. AHCCCS currently supports more than 110 GME programs training more than 1,350 residents in Arizona with annual payments to hospitals totaling more than $37 million for the direct costs of resident training.

Other Provider Recruitment and Retention Programs

Besides graduate medical education, a variety of incentives have the potential to improve recruitment and retention of providers in rural areas. They include:

- National loan repayment programs
- The J-1 visa waiver program for foreign physicians
- Community health center opportunities and support
- Educational opportunities and supervised practice experience for medical and dental students
- Residency programs
- Equitable compensation that takes regional costs into consideration

Significance to AHCCCS and Arizona

AHCCCS recognizes the importance of adequate access to health care services for all Arizonans as an effective means of maximizing prevention efforts and controlling health care costs. Its future expenditure forecast is built on the assumption that members will have access to services that are available within reasonable proximities to their homes. In addition to their impact on the quality of health care, availability and accessibility to care ultimately impact local economies. Hospitals, medical groups, community clinics, and private practice providers all serve as positive economic generators for communities around the state.

STRATEGIC ISSUE #2:
Health Care Quality and Access to Care

GOAL: Improve quality and access to care.

AHCCCS STRATEGIES:

- Improve incentives to promote health plan quality outcomes.
- Promote evidence-based treatment guidelines and best practices.
- Continue to investigate opportunities to use designated Centers of Excellence for members with high-cost and complex diseases to improve both quality of care and cost-effectiveness.
- Develop additional measures to monitor quality outcomes for long-term care recipients.
- Complete the survey process to determine long-term care member satisfaction. Data collection recently concluded, and analyses and reporting will be completed in early 2009.
- Explore the concept of a medical home for children with special needs as a means of facilitating coordination of care and streamlining the transition to adult services.
- Develop a web-based information exchange (IE) system that allows providers access to diagnosis, treatment, and other information that supports coordination of care.
- Improve members' understanding of how to access needed medical care.
- Begin making incentive payments of up to $9 million to hospitals for indirect GME costs, contingent on the hospital's creation of resident rotations in rural areas of the state.
- Improve children's oral health by promoting the establishment of a dental home by age one.
- Actively promote physician and affiliated practice dental hygienists involvement in children's oral health and disease prevention
- Provide basic dental services for adult ALTCS members.
- Provide basic oral health services to all adult members.
- Prepare for the needs of a growing ethnically diverse population by promoting cultural competence throughout the health care delivery system.
- Evaluate the networks of contracted health plans to determine their adequacy in meeting the needs of members.

PERFORMANCE MEASURES:

- Member and Provider satisfaction as it relates to quality of care
- Additional quality and utilization measures appropriate for benchmarking
- HEDIS measures and HEDIS access to care indicators
- Emergency department utilization
- Number and percent of provider types by geographical area by plan
- Number and percent of telemedicine encounters
- Number and percent of provider encounters
- Provider/Member ratios
- Member satisfaction as it relates to accessibility of care

RESOURCE ASSUMPTIONS

Dollars are shown in thousands:

Strategic Issue # 2	SFY10
FTE	-
General Funds	-
Other Appropriated Funds	-
Non-Appropriated Funds	-
Federal Funds	-
Total Funds	**$0.00**

Notes:

(1) The only Resource Assumptions included as part of this strategic issue are those that represent either new program services or administrative additions to existing programs. These are included in the agency's annual Budget Request as critical issues or decision packages.

(2) Future fiscal years are not shown as the agency is required to submit budget requests annually.

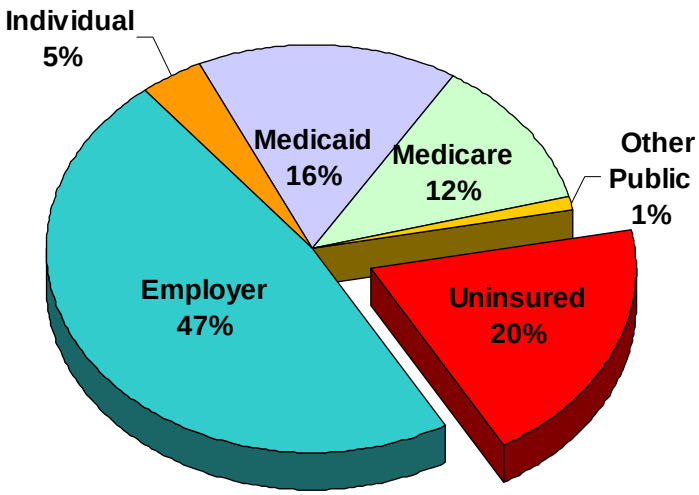
Cost Assumptions:
No additional strategic resources are included in the SFY 2010 Budget Request to facilitate this Strategic Issue.

STRATEGIC ISSUE #3: The Uninsured

***D**espite ongoing efforts to address the issue, Arizona's 20% rate of uninsured (2006-07) is growing and continues to be among the nation's highest, when compared with 15% nationwide. Over 1.2 million Arizonans are without health insurance, ranking Arizona the 9th highest state in the nation for total uninsured, and the 4th highest for rate of uninsured behind Texas, New Mexico, and Florida. A faltering economy, declining employer-sponsored insurance (ESI), and increasing medical costs and health care premiums, remain important factors contributing to the growth in the uninsured. Lack of insurance has serious health and financial consequences, affecting not only the uninsured individual, but the health care delivery system and the Arizona economy as well.*

"Arizona's 20% rate of uninsured is growing and continues to be among the nation's highest."

Arizonan's Coverage Status



Environmental Scan

National Rate of Uninsured

In an analysis of the March 2008 US Census Current Population Survey data, the Employee Benefit Research Institute (EBRI) found that, contrary to a trend that has occurred during most years since 1994, the percentage of nonelderly individuals in the United States with health insurance increased from 82.1% in 2006 to 82.8% in 2007. During the same 2006-2007 period, the number of total uninsured decreased from 46.5 million to 45 million. Among nonelderly individuals, the percentage of uninsured declined from 17.9% to 17.2%.

The nation also saw a decline in the rate of uninsured children under the age of 18, from 11.7% in 2006 to 11% percent in 2007. Still, over 8.1 million children, or one in nine children, were uninsured in 2007. Increased enrollment in Medicaid and the State Children's Health Insurance Program (SCHIP), up by 800,000 from 2006, contributed to this reduction.

EBRI noted, however, that the decline in the uninsured cannot be expected to continue in 2008. Unemployment is higher in 2008 than it was in 2007. Indeed, in October 2008, the

unemployment rate rose to 6.5%, as compared with 4.9% in January 2008 and 4.6% in January 2007. The Center on Budget and Policy Priorities noted that at 61.8%, the rate of the national population with a job is at its lowest level since 1993, and the situation is unlikely to improve in coming months. With fewer individuals working, fewer will have access to employer sponsored health insurance. Further, with rising energy and food prices, it is reasonable to expect that an increasing number of workers will reject coverage when it is offered.

The Kaiser Commission on Medicaid and the Uninsured notes that increasing unemployment rates puts pressure on state Medicaid and SCHIP programs. As individuals lose employer-sponsored health insurance and as personal income declines, state Medicaid and SCHIP enrollment–and subsequent spending–increase. At the same time, state revenues are declining. In fact, the Center on Budget and Policy Priorities reports that at least 41 states faced or are facing shortfalls in their budget for fiscal years 2009 or 2010. Unlike the federal government, which can run a deficit, most states are constitutionally required to balance their budgets. Medicaid, at 22% of total state spending, is the single largest portion of total state spending; therefore, it is frequently targeted for spending cuts during economic downturns.

Who are the Uninsured in Arizona?

Numerous key characteristics of the uninsured in Arizona and many contributing factors help to explain the lack of coverage:

- Income and Costs of Insurance: Individuals with lower income are more likely than those with higher income to be uninsured. Kaiser estimates that 69% of uninsured Arizonans in 2007 (ages 0–64) resided in households with incomes below 200% of the FPL; 36% of this age group had income below 100% of FPL. Among non-elderly adults (ages 19-64) with income below 100% of FPL, 47% were uninsured. In 2007, 100% of FPL was $10,210 for a single person and $17,170 for a family of three. Lower income ranges such as these make the purchase of private health insurance coverage nearly impossible.

  In their 2008 Employer Health Benefits Annual Survey, the Kaiser Family Foundation and Health Research & Education Trust reported that workers who had employer-sponsored insurance still paid an average of $3,354 in premiums for family coverage – a 119% increase over 1999. Total annual premiums for employer-sponsored coverage averaged $5,791 for single coverage and $12,680 for family coverage. Those without employee-sponsored insurance can expect to pay more for premiums due to an inability to negotiate group rates, and will also foot the entire cost of premiums. In short, high costs preclude low-income persons from obtaining health insurance, assuming insurers are agreeable to sell them a policy at all.

  According to a national study by the Center for Studying Health System Change, more than 57 million Americans reported problems paying medical bills, an increase of more than 14 million people since 2003. The Center found that the proportion of people with difficulty paying medical bills increased for all nonelderly people, regardless of type of insurance coverage or whether they had insurance; however, the percentage of people with medical bill problems is higher among low-income people – 31.8% in 2007 for those with incomes less than 200% of the FPL, compared to 12.4% for people in families with incomes of 400% of

FPL or higher. The Center also reported that the negative effects on access to care increase with the size and duration of medical debt. For example, a much higher percentage of people with debt of $5,000 or more reported unmet medical needs because of cost (19%) compared with those with debt of less than $500 (11.4%).

- Age and Gender: Over 38% of Arizona's uninsured nonelderly adults are between ages 19 and 29. Adults ages 19 to 29 are more likely to be uninsured (37.7%) than any other age group. This is consistent with national trends. The Commonwealth Fund notes that young adults often lose coverage through their parents or public programs at age 19 or upon high school or college graduation. At the same time, jobs available to young adults are typically low-wage or temporary jobs that do not offer health benefits.

  The rate of uninsured Arizona children under age 18 was 13.8% compared to 11%. Nearly 10% of children under age 19 with income below 200% FPL are uninsured; many of these are likely eligible for Medicaid or KidsCare but are not enrolled. This may be because families are either unaware of the opportunities or are unable to navigate through the enrollment process.

- Citizen Status: Of the 6.2 million Arizonans 11.1% (688,000) are non-citizens (2005-2007 average). Arizona is third in the nation for the highest percentage of non-citizen residents, following New Jersey (12.1%) and California (16.1%). Non-citizens are more likely to have low-incomes; 66% of Arizona's non-citizens having income below 200% FPL. Likewise, non-citizens are more likely to be uninsured; over 54% (374,000) of Arizona's non-citizens are uninsured, and 30.7% of Arizona's uninsured are non-citizens. Generally, non-citizens do not qualify for Medicaid assistance; however, they do qualify for emergency services.

- Race/Ethnicity: In Arizona, persons of Hispanic origin are more likely than others to be uninsured; 34% of Hispanics are uninsured, compared to 13% of non-Hispanics. Hispanics account for 32% of the population as a whole, but for 55% (669,000) of Arizona's uninsured. Among non-Hispanic American Indian and Alaska Natives, 26% are uninsured, and 22% of non-Hispanic black or African American are uninsured.

- Employment Status: Contrary to common perception, the vast majority of uninsured individuals are employed. In fact, 66.6% of Arizona's uninsured non-elderly adults (19 to 64) are employed. Although these individuals are employed, employer-based health care coverage may not be offered or may not be affordable.

- Reduction in Employer-Sponsored Coverage: Based on the Medical Expenditure Panel Survey for 2006, fewer than half (49.5%) of Arizona businesses offer health insurance; in contrast, the same survey estimated 55.8% of all US firms offer health coverage. Both nationally and in Arizona, large firms are more likely than smaller firms to offer health insurance: 94.8% of Arizona's firms with 50 or more employees offered health coverage in 2006, while only 32.3% of firms with fewer than 50 employees offered health insurance. In 2000, MEPS found that 96.4% of Arizona's firms employing 50 or more employees offered health insurance and 49.9% of firms with fewer than 50 employees offered health insurance.

Economic Impact

How the Uninsured Affect the Economy:
Cost Shifting Due to Uncompensated Care
Increased Government Spending
Greater Financial Stress on Providers
Lower Earnings and Educational Attainment

The uninsured have poorer health status and lower life expectancy. They receive fewer preventive and diagnostic services, often postpone care because of costs, tend to be more severely ill when diagnosed, and generally seek care in hospital emergency rooms or at safety net clinics.

The uninsured impact both the economy and the health care delivery system in Arizona. This is evidenced by:

Cost Shifting Due to Uncompensated Care: The Arizona Hospital and Healthcare Association estimates that while nearly one in five individuals are uninsured, only 7% of the state's hospital payments come from the uninsured. Charity care and bad debt assumed by Arizona's hospitals in 2006 accounted for a total of $312 million in health care services for which hospitals were not reimbursed. In 2008, Kaiser Family Foundation estimated that 61% of uncompensated care is provided by hospitals; physicians provide 14% and community providers provide 25%. These costs may be borne by providers or passed on to other healthcare consumers in the form of higher insurance premiums.

Increased Government Spending: A Kaiser Family Foundation study of spending on the uninsured estimated that uninsured individuals will receive about $56 billion in uncompensated care in 2008. Federal and state governments are the primary source of funding for uncompensated care, covering at least 75% ($42.9 billion) of the total uncompensated care costs in 2008. As the number of uninsured increases, the demand for publicly supported services increases, requiring additional allocations of public funds. According to the Institute of Medicine, the United States loses an estimated $65 billion to $130 billion every year as a result of poor health and premature deaths related to the lack of health insurance. This estimate includes lost productivity, lost value of life, and the increased economic costs of illness and death.

"The United States loses an estimated $65 billion to $130 billion every year as a result of poor health and premature deaths related to the lack of health insurance"

Financial Stress on Providers: The uninsured place financial stress on providers, especially private physicians for whom uncompensated care is not subsidized by government dollars. In order to make up for uncompensated care costs, providers may increase their rates. Ultimately these increases are reflected in the premiums that are paid by those who have insurance. Not only do the uninsured drive up costs, but they also affect provider accessibility by leading to changes in provider practice patterns (e.g., refusal to be on-call in emergency rooms).

Reduction in Earnings and Education: Lack of health insurance impacts more than physical well being. Because a lack of insurance coverage compromises health status, adults may experience reduced earning power or other employment problems. Children may exhibit poor school

attendance, lower achievement, and even arrested cognitive development, all of which compromise educational opportunities.

Additional Concerns

In the face of our nation's current economic crisis, a number of other factors have the potential to aggravate the current situation and cause an increase in the number of uninsured:

Employees Opting Not to Enroll in Coverage: Instead of opting to drop coverage altogether, many employers are scaling back coverage and shifting more of the financial burden to their employees. Employees are faced both with higher monthly premium contributions and greater cost-sharing requirements (i.e., higher deductibles, coinsurance, and co-payments). As a result, employees, especially low-wage earners, may opt to forgo employer-based coverage.

Decline in Retiree Coverage: Individuals who retire before they are eligible for Medicare benefits typically depend on employer-provided retiree health programs for coverage. However, the cost of providing these types of benefits has increased, causing employers to reconsider coverage offerings to retirees. The 2008 Kaiser/Hewitt Employee Health Benefits Annual survey estimated that among large firms, which are more likely to offer retiree health coverage, only 31% offered coverage in 2008. While this has remained relatively constant in recent years, it is substantially lower than percentages in the late 1980s and early 1990s.

Elimination of Parents with Title XIX/XXI Children: Arizona received a Health Insurance Flexibility and Accountability (HIFA) 1115 waiver to help expand coverage to parents of SCHIP and Medicaid children. Continuation of the Health Insurance for Parents Program (also known as HIFA Parents) is dependent upon continuation of federal authority to operate the program. Elimination of this program could leave 10,000 premium-paying members without health care coverage. This is disconcerting, particularly since studies show that, in many cases, participation of children in health maintenance programs is frequently higher when their families also have coverage. In addition, a majority of these parents are not offered or cannot afford employer-sponsored insurance.

Significance to AHCCCS

In keeping with its mission, AHCCCS is the principle provider of health insurance to low-income Arizonans, many of whom do not have access to affordable private sector health insurance. Arizona has successfully reduced the state's uninsured rate through major program expansion initiatives, such as the HIFA waiver (1997), KidsCare (1998), and Proposition 204 (2000). In addition, Healthcare Group, a public/private partnership administered by the AHCCCS Administration, began in 1986 and was designed to offer affordable health coverage to small businesses with 50 or fewer employees. Currently, approximately 18% of Arizonans receive coverage through the combination of these AHCCCS programs, a percentage that has nearly doubled since 1998. This percentage is based on 2008 AHCCCS enrollment numbers in comparison with the latest available annual population estimates (2007) for Arizona from the Census Bureau.

Issue #3: The Uninsured

The uninsured have serious health and financial consequences that affect the state as a whole and AHCCCS in particular. As the number of uninsured increases, the demand for AHCCCS coverage increases. It is also important to keep in mind that the uninsured have a significant impact, both directly and indirectly, on AHCCCS' rising health care costs. Upon enrollment, their health status is often poor, a factor that adds to the cost of care and directly impacts AHCCCS costs. In addition, the burden created by the uninsured impacts the viability of the health care delivery system for all consumers, including AHCCCS members, and indirectly affects AHCCCS costs.

STRATEGIC ISSUE #3:
The Uninsured

GOAL: Reduce the rate of uninsured Arizonans by providing reasonably-priced health care coverage options.

AHCCCS STRATEGIES:

- Educate the public about available programs for the uninsured and offer enrollment assistance to potentially eligible families; in doing so, collaborate with community-based organizations, faith-based organizations, schools, and school districts to conduct KidsCare outreach and informational activities.
- Evaluate other coverage options under the HIFA waiver as well as other types of strategies for maximizing the impact Medicaid and SCHIP programs have on reducing the rate of uninsured.
- Refer applicants who are ineligible for AHCCCS to alternative resources for insurance coverage and medical care.

PERFORMANCE MEASURES:

- Number and percent of uninsured adults and children in Arizona
- Number and percent of adults and children participating in AHCCCS programs
- Number and percent of employers offering health insurance to Americans and Arizonans

RESOURCE ASSUMPTIONS

Dollars are shown in thousands:

Strategic Issue # 3	SFY10
FTE	-
General Funds	-
Other Appropriated Funds	-
Non-Appropriated Funds	-
Federal Funds	-
Total Funds	**$0.00**

Notes:

(1) The only Resource Assumptions included as part of this strategic issue are those that represent either new program services or administrative additions to existing programs. These are included in the agency's annual Budget Request as critical issues or decision packages.

(2) Future fiscal years are not shown as the agency is required to submit budget requests annually.

Cost Assumptions:
No additional strategic resources are included in the SFY 2010 Budget Request to facilitate this Strategic Issue.

STRATEGIC ISSUE #4: Organizational Capacity

Success of the AHCCCS Strategic Plan is dependent upon a strong and effective infrastructure that can support the agency's work and respond to a dynamic health care environment. Organizational capacity encompasses both the human and technology elements necessary to service stakeholders. In order to further develop such a structure, the agency must focus on two critical areas:

A. *Information Technology*
B. *Workforce Planning*

Enhancing organizational capacity is critical as agencies are asked to expand services, improve cost control, reduce turnover and serve ever growing populations on relatively small administrative budgets. Organizational capacity is influenced by both the technology available to an agency and the needs of its customers. Maximizing organizational capacity allows the agency to be more effective. In the following sections, we will address how focusing on this issue, will help the agency to achieve its long term goals.

A. Information Technology

Organizations today are dependent on sophisticated information technology systems. The ongoing challenge is maintaining information technology systems that encompass the most current state-of-the-art technologies as well as meet constantly changing demands and needs of the organization. Each year, federal and state policy makers strive to meet the challenges of an increasingly complex Medicaid program, while maintaining goals of improved health outcomes and efficient administration. Ongoing enhancements to information technology systems within AHCCCS are imperative if the agency is to achieve the program goals set forth in this strategic plan.

"Ongoing enhancements to information technology systems within AHCCCS are imperative if the agency is to achieve the program goals set forth in this strategic plan."

Environmental Scan

Trends and Challenges

1. e-Government: Citizens and businesses expect to find information and conduct business, including government services, conveniently through their computer or telephone.

AHCCCS is focused on a member-centric e-government model. In 2007, *MyAHCCCS.com* was implemented for members. This is a secure verification website where members can register and create an account to securely access and maintain their demographic, eligibility, and enrollment information. Members can conduct online annual enrollment changes, make payments for premiums, if required, and email AHCCCS with concerns that need addressing. Members who provide their email address will be able to receive correspondence electronically in 2009. They will also be able to change their address, make initial enrollment choices, and link to the online application system, Health-e Arizona. Health-e Arizona, a web-based application tool to screen and apply for Medicaid, SCHIP, Food Stamps, and TANF, has been operational for seven years for community subscribers. A new version, implemented December 15, 2008, allows the public to access Health-e Arizona. Applicants create an account and complete an online application for public assistance. When the application is completed and sent, Health-e Arizona directs the application to the correct agency and office.

Also implemented was a newborn transaction that accepted valid information about a newborn, added it to the system, and issued an AHCCCS identification number along with health plan information. A special web application was created for the Health Plan contract RFP process that enabled participants to submit their bid proposals electronically. Another was developed for Healthcare Group employer group representatives, which enabled them to renew employee medical, dental, and vision plans online. A Health and Wellness website was added to provide AHCCCS members with state-specific health education, resources, and services by integrating quality, culturally-diverse, and linguistically-appropriate evidence-based health content in an effort to assist and empower them and their families to manage their healthcare, prevent illness, and ultimately improve health outcomes. An Interactive Voice Response (IVR) system provides members with an automated telephone connection to AHCCCS for purposes of renewal, etc. Future IVR enhancements will address additional matters such as prior authorization requests, health plan demographics, security and auditing infrastructure, employee access to member verification and validation, and the new Employee Sponsored Insurance program.

2. e-Health: E-health refers to the use of web-enabled systems and processes to accomplish some combination of the following goals:
    - Improve or enhance medical care.
    - Improve patient involvement in their medical care and their overall satisfaction with the health care experience.
    - Streamline operations and business practices.
    - Control expenditures.

    A large number of e-health initiatives are underway by leaders in health care, government, and hi-tech industries, in an attempt to harness the benefits of combining technology, the internet, and health care. The expansion of e-health capabilities will allow medicine and technology to meet and conquer the same challenges faced by other industries over the past 20 years: (1) the capability of consumers to obtain, view, or interact with their information online; and, (2) improve possibilities for institution-to-institution transmission of data. In

other words, providers will be able to more efficiently and accurately communicate with their patients and each other, positively affecting the overall healthcare experience. Increasing evidence shows that electronic systems and processes are vehicles that can improve the accessibility of applications; facilitate user exchange of information; and collapse time, distance, and the "information divide" for better delivery of care to patients.

Medicaid agencies across the nation are focused on transforming and modernizing the health care system for the 21st century. They are building health information exchanges and electronic health records; adding online enrollment, e-prescribing, and clinical decision making; improving fraud and abuse tracking; and enhancing medication management. AHCCCS has committed funds from one of its Medicaid Transformation Grants to the development of an HIE/EHR for the exchange of data related to the care of AHCCCS members. A second grant will focus on value-driven decision support tools to provide the right care to every person every time.

3. EDI Transactions: The health care industry standardized several electronic transactions and code sets as part of the HIPAA initiative in 2000. This was a first step in simplifying healthcare operations and integrating numerous disparate healthcare systems. Today, the standards development organizations are recommending the implementation of upgrades to these standards and the addition of numerous transactions during the next two to three years. All require extensive impact analyses for AHCCCS and its business partners. Such changes impact not only transaction processing; but, more importantly, the data analysis and reporting systems that are required to gather and translate data from the different code sets into meaningful results.

   AHCCCS is currently working on analyzing the impact of the new HIPAA 5010 transactions and the addition of the claims attachment transaction. The goal is to use standard transactions for all electronic transactions.

4. MITA: Medicaid Information Technology Architecture (MITA) is an ongoing national initiative of the Centers of Medicare and Medicaid Services (CMS) designed to modernize systems supporting Medicaid programs in each state. The MITA initiative supports moving from traditional Medical Management Information Systems (MMIS) to web-based, patient-centric systems that are interoperable within and across all levels of government.

   MITA is driven by three core architectures: Business, Technical, and Information. All three combine to form a system that aligns with unique state or organizational needs, but rely on common industry standards to make it work. MITA defines Medicaid business processes and establishes the characteristics of maturity for each. It also describes an architecture that links technology choices to business needs, and bases its information architecture on the health industry HL7 standard for identifying its data elements.

   States use the MITA maturity model to assess their Medicaid program capabilities and formulate a vision for the future. AHCCCS has performed such a self-assessment. As assessment results are reviewed, AHCCCS plans to focus on bridging any gaps between its

systems and processes and those of the MITA model, which may lead to several MITA gap-related projects.

5. Virtual Office: Virtual Office is a fully functional worksite that is not bound to a specific location. Portable and scalable, it connects employees to the work process without requiring them to travel to a central office. This environmentally-friendly alternative to the daily commute helps employees save on travel costs and time, and helps agencies reduce real estate and operational costs. More and more organizations are offering Virtual Office as one of a variety of choices offered an employee.

   Though the implementation of Virtual Office at AHCCCS has presented challenges, including a cultural shift for both employees and the organization, it has proven most beneficial. To enhance the communication and collaboration of all employees, AHCCCS has implemented new tools, including web-conferencing and e-learning. Benefits of Virtual Office to the state of Arizona include reduced fuel consumption, pollution, and traffic congestion. Employee benefits include reduced stress, increased job satisfaction, improved quality of life, a feeling of increased respected from leaders, and increased job opportunities for individuals who are homebound or who live in rural areas. Agency benefits include increased employee retention, reduced absenteeism, expanded hours of availability, increased productivity, and reduced operational costs. In addition, the agency has been able to close three large facilities, downsize four other facilities, and reduce the number of copiers, printers, supplies, and vehicles in its fleet.

   Approximately 28% of the agency is currently working in a Virtual Office environment, and a similar number work from home or telework one day or more a week. AHCCCS plans to continue to support and expand these worksite alternatives.

6. Service Oriented Architecture (SOA): SOA promises to let an enterprise make its applications and computing resources available as "services"–components that can be flexibly reused and recombined. For instance, a health information exchange would have a component for exchanging data—a data exchange service. Each entity that wants to exchange information would use that service. Once an entity had modified its systems to interface with the data exchange service, it would be able to be to exchange data with all of the other entities that are using that service. If all were using the service, a physician could access a patient's lab results, medications, emergency room visits, and so on, without having to develop direct interfaces with the laboratory or the pharmacy or the hospital. SOA offers a more efficient means of exchanging information and speeding execution of the business processes.

7. IT Budgets and Resources: Business needs, technological changes and refreshing of equipment continue to challenge agency IT budgets. With a new generation of IT arriving every 18 months (per Gartner Group), the continued lack of funding for technology refresh and infrastructure improvements impacts the agency's ability to maintain quality service, increases maintenance costs, and leads to increasing production problems that impact critical business functions. During the past 10 years, AHCCCS's technology refresh plan has only been funded for one year, leaving the agency with outdated and poor-performing equipment.

Only with a well-funded technology plan will we be able to effectively support the dynamic nature of the agency.

As an alternative to the continuing purchase of PCs, AHCCCS replaced many PCs with thin client devices. Thin clients have fewer moving parts and last longer than traditional PCs; they are also more secure. In addition, the agency has begun to virtualize some of its servers and PCs. These changes help to reduce replacement costs and increase investment longevity.

Further, of great concern to the agency budget is the continual shortfall of funds to meet the increasing costs of operating mainframe systems at the ADOA Data Center. AHCCCS's projected expenditures are never fully funded, causing the agency to routinely search for other funding to meet these expenses.

8. PMMIS Aging System: AHCCCS's legacy system, the Prepaid Medical Management Information System (PMMIS), is 17 years old and uses older technology to operate. It is becoming increasingly more difficult to implement federally-required changes. Database and programming languages are currently supported, but no major improvements are planned in the near future. Trained staff resources are limited, most being trained in-house. With two states to consider (both Arizona and Hawaii), it is necessary to develop an overall strategy for the future that addresses the expected life of the system (or individual components), the direction of the market as a whole, statewide enterprise and service-oriented architectures, e-Health, MITA, and federal and state regulations.

   As stated in Point 4 above, AHCCCS performed a MITA self assessment and prepared a roadmap of systems enhancements to reach an increased level of process maturity. AHCCCS is also identifying new and innovative ways to address current suboptimal operations. It is important that these plans be put into action before PMMIS can no longer meet agency, state, and federal needs.

9. Retention and Recruitment of Staff: A continuing issue facing IT management today is the retention and recruitment of technical staff. Without competent staff, knowledgeable of and trained in current technologies, this Strategic Plan cannot be accomplished. Enterprises worldwide are requiring additional resources to adopt new technologies and remain competitive in the marketplace. At the same time, there is an overall shortage of skilled IT personnel, hiring freezes are routine in government, and many private enterprises are offering salaries with which the government cannot compete. The need of government to change its personnel management to reflect private sector practices (e.g., frequent pay raises based on market rates, performance bonuses, simplified job/salary classifications, and streamlined hiring and firing procedures), has been recognized nationally.

   Staff retention and recruitment is not just an IT problem, but is common in many divisions across the agency. To help combat this issue, AHCCCS recognized the need to invest in advanced technology to support distributed work processes. Telecommuting has been made available as a work-site alternative, and many employees telecommute one or more days per week. A Virtual Office pilot was undertaken in FY 2006, during which time, employees worked in their homes on a permanent basis. Currently, about 28% of the agency work at

home permanently. Virtual Office has caused a reduction in turnover from 25% in early 2006 to 12% currently.

10. Cloud Computing and Software as a Service (SaaS): Cloud Computing is a concept whereby users can access IT services via the Internet, in effect "renting" these services without the need for large capital investment or management of the infrastructure. Gartner has predicted that Cloud Computing will be as influential as E-Business has already proven to be.

    Currently, offerings in this environment are somewhat limited but new SaaS and Cloud Computing opportunities are being made available. AHCCCS will continue to monitor and evaluate the offerings in this environment.

Value Driven Health Care and HIeHR Utility

As already stated within the "Value Driven Health Care" section of the Introduction to this plan, AHCCCS is currently making significant progress towards formalizing Value Driven Health Care. AHCCCS was awarded $11.8 million under a federal Medicaid transformation grant from the Centers for Medicare and Medicaid Services (CMS) in February 2007 to create a statewide, web-based secure Health Information Exchange utility and Electronic Health Record Utility (HIeHR utility). The secure web portal will give providers instant access to electronic health records where and when the information is needed for care. Additionally, a second grant totaling $4.4 million was awarded in November 2007 for development of a Value Driven Decision Support Tool Box.

Interoperable Health Information

The HIeHR utility will address the first cornerstone of interoperable health information systems. Interconnectivity allows for better exchange of clinical data, resulting in more accurate diagnoses and appropriate care. In addition, the availability of data will reduce redundant laboratory and radiology procedures, resulting in a decrease in healthcare costs assumed by AHCCCS and by the entire healthcare system.

HIeHR Utility Project Phases

The HIeHR utility is being implemented in three integrated phases:

- PHASE 1 focuses on the development and use of a statewide health information superhighway (the HIE) that includes the exchange and web-based display of three key types of health care information: hospital discharge summaries, medication history, and laboratory test results. This new health information exchange, which was launched on September 29, 2008, has been named the Arizona Medical Information Exchange (AMIE). The three-month proof of concept includes hospital discharge summaries from five Banner Health hospitals, Maricopa Integrated Health System Hospital, and St. Joseph's Hospital in Phoenix, Arizona. AMIE also includes lab test results from Sonora Quest labs and medication histories from Managed Care Pharmacy Consultants Inc. Approximately 40 clinicians were selected and volunteered to participate in the use and evaluation of AMIE. An assessment report to

include value/benefit analyses, and lessons learned from the proof of concept, will be delivered in January 2009. Following this evaluation, it is anticipated that an AMIE pilot (mid-2009) will include more health information types and permit access to a wider group of participants via a secure web viewing portal.

- PHASE 2 includes the design and creation of an AHCCCS clinical data repository to complement the current transactions data warehouse. The availability of the clinical data repository will make a spectrum of specialized applications, known as clinical decision support tools, available to providers, plans, and patients. These functions will help make getting the right care easy and efficient and will enhance prevention, wellness, and illness programs across the continuum of care.
- PHASE 3 is aimed at fostering electronic health record (EHR) adoption among Arizona clinicians. This phase involves coordination of AHCCCS health plan e-health incentives and a community EHR purchasing program. Slated for initiation this winter, the AHCCCS Collaborative Purchasing Program (CPP) plans to feature a certified, web-based EHR selected through a Request for Proposal (RFP) process. The selected EHR will include the following modular features:
    - Clinical notes (medical history, problem list, SOAP notes)
    - E-Prescribing (medication list, allergies, interactions, formularies, refills)
    - E-Referrals (Continuity of Care Record (CCR), attachments)
    - Interfaces with lab, radiology, hospital, and other key service providers
    - Standard and ad-hoc reporting modules (quality measures, EPSDT, Medical Home)
    - Eligibility verification
    - Practice management (financial & administrative)
    - Patient portal

  Although preference will be given to registered, active AHCCCS providers, clinicians providing care for state employees and others will also be eligible. Members of the CPP will be eligible for:

    - Affordable monthly subscription for a certified, web-based electronic health record (EHR), including support and maintenance
    - Tiered discounts and/or special arrangements for part-time providers and students
    - Group purchase rates for hardware and other services
    - Help with planning, selection, set-up, training, implementation and policies
    - Contract management and expedited issues resolution
    - Facilitated user forum

Business Continuity Preparations

Working with the Governor's Emergency Oversight Council, AHCCCS seeks to ensure the continued operation of its essential government functions during a wide range of potential emergencies and service disruptions. As part of its Continuity of Operations Planning, or Business Continuity Planning, the agency invests in ongoing staff training to be able to respond in the event of an emergency or adverse condition while maintaining communications, services,

and operations capabilities. . At the same time, AHCCCS invests in building an infrastructure to support mission critical functions as technologies move us in a direction of more servers and less mainframe.

Significance to AHCCCS

To summarize, technology is critical to more than just the reporting systems within the agency. Technology affects employees and customers by offering additional opportunities to enhance customer service and offering employees additional work option flexibility. AHCCCS is dependent on these systems in order to:

- Control health care costs, improve service delivery, and integrate program operations.
- Provide data reporting functions that support decision-making and strategic planning.
- Ensure effective communication with stakeholders (e.g., members, providers, and other stakeholders).
- Reduce turnover and training costs by offering options such as Virtual Office to employees.
- Enhance efficiency within and between agencies through the use of imaging and reduce the costs to store paper records.
- Provide enhanced web based services to health plans, members and providers while reducing the time employees spend responding to routine requests such as address updates.

B. Workforce Planning

Workforce planning is a critical and integral component of strategic planning. The right number of appropriately qualified workers must be available at the right time and in the right place if AHCCCS is to achieve its goals and accomplish its mission. With projected increases in both population and healthcare needs, AHCCCS can expect to see an increase in the demand for agency services. It can also expect to see heightened competition for vital talent at a time when its knowledgeable workforce is aging and retiring, Accordingly, it is faced with the challenge of attracting, developing, and retaining a workforce that is competent to address new objectives, new technology, and new operational requirements. Effective workforce planning allows for the building and shaping of a workforce prepared to meet strategic objectives.

"…workforce planning is a critical and integral component of strategic planning."

Environmental Scan

What is Workforce Planning?

Workforce planning is a systematic process for identifying the human resources required to meet agency goals, and developing the strategies to meet these requirements. According to the National Academy of Public Administration, an organization chartered by Congress to improve government at all levels, workforce planning involves:

- A systematic process that is integrated, methodical, and ongoing.
- Identification of the staffing needs required to meet agency goals; this involves determining the number and skills of needed workers and identifying where and when they will be necessary.
- Development of a plan to meet these requirements, which involves identifying actions necessary to attract and retain the number and types of workers the agency needs.

Establishing a Workforce Plan

A Workforce Plan is a living document that matures with the organization. The U.S. Department of Health and Human Services suggests that, in order to be effective, a workforce plan should incorporate:

- Supply Analysis: Identifying organizational competencies, analyzing staff demographics, and identifying employment trends.
- Demand Analysis: Analyzing future activities and workloads, and describing the competency set needed by the future workforce.
- Gap Analysis: Comparing findings from the supply and demand analyses to identify the gaps between current competencies and those needed in the future workforce.

- Solution Analysis: The process of developing strategies for closing gaps in competencies and reducing surplus competencies through strategies such as recruitment and training.
- Evaluation: A systematic review of the workforce plan to ensure that it remains consistent with the agency's mission.

AHCCCS is committed to the development and maintenance of a workforce plan that incorporates the general steps described above and addresses a number of key components including:

- Identification and Assessment of Core Competencies: Identifying and assessing department- or unit-specific competencies in relation to individual strengths and weaknesses, motivation, and personal values.
- Succession Planning: Identifying potential successors for key positions within the organization.
- Recruitment and Retention: Enhancing the effectiveness of hiring practices by using core competencies to structure the selection process and retaining employees longer through effective incentives and opportunities (i.e., salary packages, position progression, and Virtual Office opportunities).
- Performance Management: Aligning individual competencies with performance goals.
- Leadership, Employee, and Organizational Development: Using core competency gaps as a road map to guide employee training, and developing managers through ongoing education and promotional opportunities.

Key Issues

The recruitment and retention of a competent workforce that supports the success of AHCCCCS depends on having the right employees with the right competencies at the right time. Workforce planning provides managers the means of identifying the competencies needed in the workforce, not only in the present but also in the future, and then selecting and developing the workforce. Some key issues that impact and are impacted by the AHCCCS workforce include:

- **Increasing Retirement**: Given the anticipated departure of older workers and the loss of their institutional knowledge, AHCCCS will be challenged with preserving and redistributing this critical information and retaining a skilled and effective workforce while addressing gaps in skills, abilities and knowledge needed for the future. AHCCCS employed 1,288 employees in SFY 2008. Current analyses indicate 9.1% of the agency's active employees will be eligible for retirement by 2009, and 24.3% will reach retirement age by the year 2013. This rate is may be increased by non-retirement issues.

- **Absenteeism and Turnover:** The average number of sick days used by AHCCCS employees in SFY 2008 was 9.3 days at an average cost of $1,386 per employee. These figures are slightly lower than the state's overall average. The agency's turnover rate decreased from 25.0% in SFY 2006 to 18.9% in SFY 2007 to 13.0% in SFY 2008, due in large part to the success of Virtual Office. Although AHCCCS turnover for SFY 2008 is

lower than the 14.8% overall state average, it is higher than the 11.3% turnover rate of other local public employees. Estimates of the total cost of losing a single person to turnover range from 30% to 150% of their yearly salary (as stated separately by Cornell University, Saratoga Institute, and Hewitt Associates). Costs to the agency may include decreased productivity, costs of hiring a new employee, increased training time, and other indirect costs.

- **Budget Constraints**: AHCCCS membership continues to grow and its programs expand within the context of budget constraints that limit full-time positions and salaries, challenging recruitment and retention efforts. Despite recent state salary increases, the current analysis of market competitiveness suggests the market exceeds state salaries by an estimated 9.5%.

- **Changes in Technology**: As new technology continues to impact how work is performed on the job, a shift toward higher-skilled knowledge based workers is occurring. While this is a challenge to the agency in terms of recruitment, one of the benefits from new technology is that it also offers employees opportunities to work from alternate sites, including their homes, and reduces the time spent on repetitive routine tasks that can lead to employee burnout.

Significance to AHCCCS

Understanding these environmental realities and using them as a call to action, AHCCCS will be able to employ strategies to build and maintain an effective workforce. Focusing on developing leaders from within the agency will benefit AHCCCS and assist in employee retention efforts. Offering employees opportunities such as training and career development is likely to result in improved job satisfaction and a clearer understanding of and appreciation for their roles in overall AHCCCS operations. In addition, the opportunities afforded by Virtual Office and flexible work schedules have helped to attract and retain a more stable workforce.

In the face of uncertain state budgetary factors, it is also necessary to streamline operations to meet the service needs of AHCCCS members, partners, and other constituents with as few staff as possible. AHCCCS's ability to do this is based on intensive IT support, a very stable and productive workforce, redeployment of the workforce to critical areas, and aggressive prioritization of projects and performance measures.

STRATEGIC ISSUE #4:
Organizational Capacity

GOAL: Maximize agency capacity and resources and address workforce issues through the use of technology and planning.

AHCCCS STRATEGIES:

- Strengthen the AHCCCS Department of Member Services (DMS) workforce through innovative recruitment methods, focused leadership development, and increased workplace flexibility.
- Expand self-service opportunities for members and applicants through enhancements to Health-e-Arizona, *MyAHCCCS.com,* and IVR.
- Modernize DMS through the elimination of non-essential tasks, creation of efficient processes, restructure of work, maximization of current resources, and implementation of a continuous improvement cycle.
- Evaluate, acquire and install the next generation of AHCCCS software products and system architecture.
- Continue our partnership with Hawaii to share costs of developing and maintaining our Medical Management Information System and Data Warehouse.
- Implement National Provider Identification (NPI).
- Maximize the use of upgraded telecommunication capabilities.
- Design and implement expanded web-enabled capacity and capabilities, including the transformation of paper processes into electronic transactions/processes.
- Maximize the organization's ability to utilize data warehousing for reporting and decision-making.
- Continue to reduce the number of reports run against the Department of Administration's mainframe computer to reduce current data center costs incurred by AHCCCS.
- Continue to expand the Virtual Office environment to improve productivity and facilitate recruitment and retention of staff while decreasing infrastructure costs.
- Continue to address potential barriers/issues related to Virtual Office such as distance training/learning, recruitment from targeted populations, promotion issues and facility transition as offices are closed.
- Implement an employee development program.
- Implement recommendations from the Diversity Council.
- Continue to improve the hiring process to attract and retain a highly-competent workforce.

PERFORMANCE MEASURES:

- Customer satisfaction with IT functions
- Per unit transaction costs (i.e., eligibility, member services, and claims)
- DOA Data Center hours charged to AHCCCS
- Timeliness of hiring
- Individual and organizational performance objectives
- Employee satisfaction
- Employee grievances, complaints, and resolutions
- Number of eligible employees participating in Virtual Office
- Rate of employee turnover
- Rate of absenteeism
- Number of *MyAHCCCS.com* registered users

RESOURCE ASSUMPTIONS

Dollars are shown in thousands:

Strategic Issue # 4	SFY10
FTE	27.0
General Funds	$ 3,139,700
Other Appropriated Funds	398,100
Non-Appropriated Funds	0
Federal Funds	4,560,500
Total Funds	**$ 8,098,300**

Notes:

(1) The only Resource Assumptions included as part of this strategic issue are those that represent either new program services or administrative additions to existing programs. These are included in the agency's annual Budget Request as critical issues or decision packages.

(2) Future fiscal years are not shown as the agency is required to submit budget requests annually.

Cost Assumptions:

The following strategic resources are included in the SFY 2010 Budget Request to facilitate this Strategic Issue.

NETWORK SECURITY SOLUTION: AHCCCS requests $767,000 Total Fund ($370,200 General Fund) to fully implement its network security measures. The Government Information Technology Agency (GITA) Statewide Policy P800 IT Security Policy and the Federal Health Insurance Portability and Accountability Act (HIPAA) establish security guidelines for the protection of IT assets and resources, including data and information. AHCCCS relies on network connectivity to deliver and support mission critical services. To ensure the network is resilient and available to support agency-critical applications and a workforce that depends on availability of services and information, it is important to secure and protect the network against attack from inside and out. Unauthorized access to the AHCCCS computer network or malicious activity by authorized users could disrupt the ability of the agency to function, and compromise member and agency data include private health information. AHCCCS Information Services Division (ISD) currently employs a number of network security measures. However, additional threat protection solutions are necessary to improve data security of the AHCCCS network infrastructure.

SECURITY THREAT MITIGATION: AHCCCS requests $1,015,000 Total Fund ($489,800 General Fund) to mitigate its security threats through expanded encryption technology. Per Executive Order 2008-10, the State (including AHCCCS) must endeavor to protect confidential information it acquires from its citizens and businesses through the deployment of encryption technologies. Encryption technologies protect confidential information during transmission over State networks and in storage by using algorithms and a key mechanism which renders information unreadable for unauthorized intruders on State systems. The information is mathematically protected against disclosure and cannot be read by someone who does not have a corresponding key to decrypt the information. Encryption is a defense-in-depth strategy for the protection of informational assets of the State. AHCCCS currently encrypts confidential information which is transmitted externally; however, it does not encrypt data at rest or stored data. In addition, per statewide standard P800-S850 Encryption Technologies, all confidential information residing on Direct Attached Storage (DAS) devices, Network Attached (NAS) devices, and Storage Area Network (SAN) devices, and all portable devices, shall be encrypted and compatible with statewide communications and security protocols and with State platform operating systems. There is a security threat associated with all stored data that must be mitigated.

HIeHR – HEALTH INFORMATION EXCHANGE & ELECTRONIC HEALTH RECORD UTILITY OPERATIONS: AHCCCS requests 10.0 FTE and $2,769,700 Total Fund ($715,900 General Fund) to fund the ongoing operations of a Health Information Exchange (HIE) to achieve the goal of giving all Medicaid providers instant access to beneficiaries' health records via electronic connection at the point of service. Implementing this HIE will transform the AHCCCS Medicaid program and the patient care process. Providing timely patient health information at the point of service will improve the quality, efficiency and effectiveness of Arizona's Medicaid program. Real time health information access will result in reduction of medical errors, reduction of redundant testing and procedures, better coordination of care for chronic diseases, increased preventive interventions, reduction in the inappropriate use of the emergency room, and lower administrative costs. Savings will initially be for health plans and providers which will result in lower capitation rate increases and fee-for-service per member per enrollee cost increases, thus reducing the AHCCCS programmatic budget requirements in future years. CMS has indicated that 75% Federal Financial Participation (FFP) will be available for costs associated with operating the Utility. There is strong support at the Federal level for these initiatives and the potential for savings that they will achieve.

CRITICAL HARDWARE AND SOFTWARE REPLACEMENT: AHCCCS requires funding of $1,855,600 Total Fund ($1,027,200 General Fund) for critical hardware and software replacement. AHCCCS has implemented a number of initiatives that are cost effective and have created efficiencies for the agency, employees, and residents of Arizona. These initiatives – virtual office, telecommuting, thin client deployment, and imaging are dependant upon technology. The technical infrastructure must be updated and maintained in order to support these initiatives for the agency's critical business functions. Failure to replace old equipment results in a decline in employee productivity, increased repair and maintenance costs, and a lack of support for existing systems. According to the AHCCCS Strategic Plan, "Ongoing enhancements to information technology systems within AHCCCS are imperative if the agency is to achieve the program goals set forth in this strategic plan."

ELECTRONIC CLINICAL DECISION SUPPORT (ECDS) SYSTEM OPERATIONS: AHCCCS requests 14.0 FTE and $1,306,900 Total Fund ($351,200 General Fund) to fund the ongoing operations of ECDS, Electronic Data Interchange (EDI) and Enterprise Intelligence activities. AHCCCS is proposing to implement a series of technically and strategically aligned initiatives whose primary objective is to fundamentally transform how the agency transmits, receives and consumes administrative and clinical information. Benefits from these improvements will cascade throughout the entire Medicaid enterprise in the form of increased efficiencies, accuracy, timeliness, compliance, transparency and enhanced decision support capabilities that will lead to a healthier population and a more responsive Medicaid program. Developing and implementing these capabilities will reduce overpayment and process waste or inefficiencies, including administrative waste; improve fraud and abuse identification; improve oversight of program contractors (agency core business); improve population health; align the AHCCCS Enterprise with CMS MITA Initiative; use or work to support standards for data exchange; and effectively share information with other entities serving AHCCCS members while ensuring member privacy and data security.

E-LEARNING INITIATIVE - REDUCE HEALTH DISPARITIES AND RAISE AHCCCS MEMBER HEALTH LITERACY: AHCCCS requests 3.0 FTE and $384,100 Total Fund ($185,400 General Fund) to fund the ongoing initiative to reduce health disparities, raise health literacy, and member health care self management. Low health literacy in the Medicaid/SCHIP population is the number one barrier to reducing health disparities. Current approaches to raising health literacy have been suboptimal and ineffective at best. Improving Medicaid beneficiaries personal health knowledge and increasing health literacy in the Medicaid and SCHIP population is critical to improving the overall health, treatment compliance, reducing health disparities, and enhancing member's competence to better manage their own personal health. AHCCCS has invested significant federal dollars to develop health e-learning programming for raising health literacy and training members in self management of their health care. AHCCCS is requesting funds to continue this initiative. This initiative would expand access to web based health e-learning modules by installing internet connected e-learning workstations in provider offices and clinics. Medicaid and SCHIP patients would have access to easy-to-use and navigate health e-learning programs and instructional material geared to the learner's education level, language, and culture. Web based health e-learning programs are an effective and adaptable tool for raising AHCCCS members' health literacy.

COLLABORATION and INTEGRATION of Health Care Programs

***A** major variable in the success of the AHCCCS Strategic Plan, and a critical component associated with the aforementioned key issues and their respective strategies, is the ability to form effective partnerships with key stakeholders. Successful collaboration increases capability, multiplies resources, fosters communication, improves continuity of care, and limits the duplication of costly services.*

Importance to Strategic Planning

Today's health care environment is one of increasing demands and diminishing resources, creating a challenge to sustain access to effective care for recipients and improve efficiencies for delivery systems. Recent literature suggests that the traditional "silo" model of multiple agencies administering multiple programs by themselves is giving way to one-stop services and cross-agency results. This change implies collaboration – within agencies; among agencies; among levels of government; and among public, private, and non-profit sectors.

Collaboration should be an integral part of the goals and strategies designed to support and influence the issues, initiatives, and key topics addressed in this plan. This is due to a variety of circumstances, including:

- An increasing need to control costs by leveraging resources
- A growing idea of government as a series of enterprises rather than a series of agencies
- A blurring of public and private roles
- An increased use of technology, making it easier to share resources and information

A recent study involving a survey of 412 government representatives, primarily from state and local levels, examined the effectiveness of cross-agency investment, particularly in information technology (IT) infrastructure. Better information collection and distribution as well as customer service were the primary benefits realized by all cross-agency IT initiatives.

Medicaid agencies, in particular, have had increasing opportunities to participate in multi-agency efforts. A national survey of state systems addressed state agency activities and interagency collaboration related to employment opportunities for people with disabilities. The survey asked Medicaid agency representatives to indicate the specific methods used to collaborate with other state agencies. Based on the responses, methods of collaboration included three basic types:

- Activity Methods, such as cross-agency awareness training and the development of multi-agency groups, were most common.
- Structural Methods were longer-term, more involved approaches relating to physical and organizational structure, such as sharing physical space as well as IT networks and information.

- Financial Methods, such as sharing of funds across agencies, were effective but less common.

Arizona has already realized successes as a result of such approaches. A number of ongoing state programs exemplify the value of collaboration:

- Baby Arizona: This statewide project initiated by AHCCCS acts in partnership with other public and private organizations. The project promotes early access to prenatal care by streamlining eligibility for medical coverage for pregnant women and is perhaps one of the best examples of true collaboration. The program has been successful for nearly 12 years, facilitating timely prenatal care for many Arizona women.
- Hawaii and Arizona PMMIS Alliance (HAPA): HAPA is a collaborative project between the two state Medicaid agencies that allows for sharing of IT resources. The Prepaid Medical Management Information System (PMMIS) was designed specifically for Arizona's managed care Medicaid program. Under the agreement, Arizona runs and operates the application system for Hawaii's program as well as for its own. Both states share the costs of operation and maintenance of the core system, maximizing use of IT dollars.
- Medicaid School Based Claiming: This program is the result of an agreement between AHCCCS and the Arizona Department of Education (ADOE) that allows AHCCCS to use federal funds to reimburse school districts for medical services provided to Medicaid-eligible students in special education classes. Previously, these services were purchased by the schools with state-only funds. This leveraging of resources leads to more effective and efficient care for disabled children and reduces duplication of services.

Significance to AHCCCS

Arizona delegates responsibility for health concerns to more than one agency, making collaboration a vital process to ensure efficient and effective use of resources. AHCCCS presently works most frequently with both ADES and ADHS through intergovernmental agreements that affect matters such as eligibility determination and behavioral health system services. In addition, less formal collaborations exist between the agencies, addressing specific interests such as grant opportunities and public health initiatives. It is important that AHCCCS continue to partner with other entities and to formalize these collaborations to make them more effective and accountable for achieving mutually desired results. This means working with the staff of partnering entities to establish common expectations. A significant number of the programs administered by AHCCCS, ADES and ADHS involve mutual constituents. By maximizing opportunities for collaboration, we can achieve greater results using fewer resources and, ultimately benefit from the synergy that comes from working together.

"By maximizing opportunities for collaboration, we can achieve greater results using fewer resources."

Collaboration is not limited to sister state agencies. Key stakeholders in both public and private, sectors may collaborate on projects to improve health care availability and access. For example,

AHCCCS may collaborate with Federally Qualified Health Centers and telemedicine centers to improve access to care for AHCCCS recipients as well as the uninsured, employees of small businesses, state employees, and retirees. Collaboration may include working with small businesses to develop products that will meet their needs and budgets. Collaboration may involve working with AHCCCS providers to establish rates that more equitably compensate them for the costs of care.

AHCCCS approaches collaboration with the understanding that all participants stand to gain from the experience. By maximizing collaboration opportunities, AHCCCS expects to streamline and improve service delivery, realize cost savings as a result of greater efficiencies, and ultimately improve the health of all Arizonans.

ACCOMPLISHMENTS

***I**n seeking to meet challenges presented by its four strategic issues, AHCCCS achieved the following significant accomplishments during Calendar Year 2008:*

	STRATEGIC ISSUE(S) SUPPORTED BY ACCOMPLISHMENT			
ACCOMPLISHMENT	COSTS	QUALITY	UNINSURED	ORG. CAPACITY
Rate Restructuring: In support of a manageable, equitable, and predictable payment structure, AHCCCS continued to review and adjust reimbursement rates. Appropriate rates ensure continued participation of valued providers.	X	X		X
Membership Management: AHCCCS is committed to controlling unnecessary program expenditures by implementing strategies to ensure members are enrolled in the most appropriate AHCCCS programs. In SFY 2007, AHCCCS continued to work with Arizona Department of Economic Security (ADES) to identify the key barriers to accuracy, develop and implement training for staff, monitor progress, and propose best practices for implementation statewide.	X	X	X	X
American Indian Health Initiative (AIHI): The agency continued the AIHI, a collaborative effort with Indian Health Service (IHS) and the tribes. The goal of AIHI is to maximize the 100% federal pass-through reimbursement to IHS and 638 tribes, thereby enabling IHS and the tribes to expand their facilities and services for American Indians.	X	X		X
Graduate Medical Education: In FY 2008, AHCCCS made its second annual distribution of funds for direct GME costs for new and expanded GME programs. It also began making incentive payments to hospitals for indirect GME costs, contingent on the hospital's creation of resident rotations in rural areas of the state. This first distribution for indirect GME added more than $1.7 million to the support of GME programs in Arizona. AHCCCS also entered intergovernmental agreements with Maricopa and Pima counties to facilitate their contributions to GME funding for hospitals in their respective counties. Together with federal matching funds, county contributions added $24 million of funding for indirect GME costs at three training hospitals.		X		X

ACCOMPLISHMENT	STRATEGIC ISSUE(S) SUPPORTED BY ACCOMPLISHMENT			
	COSTS	QUALITY	UNINSURED	ORG. CAPACITY
Pediatric Development Tool: Based on recommendations of the School Readiness Board Health Implementation Team, and in collaboration with the Arizona Academy of Pediatrics, AHCCCS developed and implemented an assessment program for children at risk for developmental delays. Infants admitted to the Newborn Intensive Care Unit at birth are screened using the Parent Evaluation Developmental Screening (PEDS) tool. Physicians who are trained to use this tool are reimbursed by AHCCCS for the screening. As a result of this early evaluation, selected infants are referred for additional assessments and services related to individual developmental needs, improving the likelihood of positive outcomes.	X	X		
Childhood Obesity: AHCCCS implemented a childhood obesity program in Pima County at two Federally Qualified Health Care Centers and one hospital system. Criteria for enrollment and treatment are based on medical guidelines developed by AHCCCS and approved by various medical associations in Arizona. Careful data collection and analyses will facilitate outcomes reporting in future years.	X	X		
Performance Measure Improvements: AHCCCS completed its annual report of performance measures related to access to care and preventive health services received by members enrolled with acute-care contractors, based on HEDIS methodology. Rate increases were noted in a number of categories including: (1) children's' and adolescents' access to primary care practitioners (PCPs), (2) adults' access to preventive and ambulatory health services, (3) well-child visits in the third through sixth years of life, (4) adolescent well-care visits, (5) breast cancer screening, and (6) cervical cancer screening. In addition, rates of adults' access to preventive/ ambulatory health services, well-child visits in the first 15 months of life and annual dental visits among Medicaid members exceed the HEDIS national means for Medicaid health plans. Among KidsCare members, rates of well-child visits in the first 15 months of life, well-child visits in the third through sixth years of life, adolescent well-care visits and annual dental visits also exceed the HEDIS national Medicaid means. A separate measurement of childhood immunization rates completed in 2008 showed continued high levels of recommended vaccinations by 24 months of age. Using HEDIS methodology, the AHCCCS overall	X	X		

rate (Medicaid and KidsCare members combined) for completion of all doses of vaccines known as the 4:3:1:3:3:1 series was 81.4%, exceeding the national Healthy People 2010 goal and the national HEDIS means for both Medicaid and commercial health plans. Measurements of services received by ALTCS members with diabetes also showed continued high levels of performance. AHCCCS rates for all three diabetes measures – hemoglobin A1c testing, lipid screening, and eye exams – exceed the most recent HEDIS Medicaid means.				

	STRATEGIC ISSUE(S) SUPPORTED BY ACCOMPLISHMENT			
ACCOMPLISHMENT	COSTS	QUALITY	UNINSURED	ORG. CAPACITY
Performance Improvement Projects (PIPs): A number of PIPs currently underway place intensive efforts on improving specific areas of need. In CYE 2004, AHCCCS implemented a PIP for childhood immunizations. The focused interventions by health plans appear to have had a positive effect on improving completion of childhood vaccinations by 24 months of age. Another PIP, focusing on increased physician reporting of vaccinations to the state immunization registry, which is intended to help maintain improvements in immunization completion rates among children and adolescents, has shown significant and sustained improvement in the three years since the project was initiated. Both projects were conducted in collaboration with the Arizona Department of Health Services (ADHS) Immunization Program Office and The Arizona Partnership for Immunization (TAPI), a public/private partnership. By utilizing resources of the Arizona State Immunization Information System operated by ADHS and collaborating with TAPI, AHCCCS health plans and community organizations, AHCCCS increased its capacity to reach and educate members on the importance of immunizations, as well as educate providers in the use of the registry. This approach has streamlined data collection, made more efficient use of resources, improved service delivery through the availability of timely immunization data for individual members, and should ultimately improve the health of children enrolled in AHCCCS by protecting more of them from infectious diseases.	X	X		

ACCOMPLISHMENT	STRATEGIC ISSUE(S) SUPPORTED BY ACCOMPLISHMENT			
	COSTS	QUALITY	UNINSURED	ORG. CAPACITY
Adult ALTCS Dental Program: In 2007 the Arizona legislature approved funding for an adult dental benefit under the ALTCS program. With the understanding that oral health is the number one unmet health care need among developmentally-delayed adults and senior citizens, the Governor approved a budget that included this new benefit. By the end of SFY 08, many ALTCS members were able to obtain dental services never before available to them. In July 2008, the program was suspended due to budget constraints.	X	X		
Children's Oral Health Performance Improvement Project (PIP): For the measurement period ending September 30, 2007, the overall rates of annual dental visits for both Medicaid and KidsCare populations increased over the previous year. Since this PIP was implemented in 2003, the rate of children 3 through 8 years of age enrolled in either Medicaid or KidsCare who had one or more annual dental visits has increased from 52.2% to 71.6%. The rate is well above the national Medicaid mean.	X	X		
Health-e-Arizona: AHCCCS transferred Health-e-Arizona (HEA) from El Rio Health Center to AHCCCS in 2008. HEA is a web-based, eligibility screening and application referral system, enabling Arizonans to apply electronically for health and social service programs with assistance from trained application assistors. Community organizations work in partnership with AHCCCS, the Arizona Department of Economic Security, and community programs to provide a one-stop application process. Application assistors in community organizations use HEA to help families apply and submit required documentation. Built on a user-friendly Microsoft platform, the application is available in both English and Spanish. HEA provides a "preliminary" eligibility determination and electronically routes the application to the appropriate state office(s) for formal processing.	X	X	X	X
Some Arizona communities have developed discount medical networks to serve those who do not qualify for AHCCCS programs. If the organization using HEA is part of the provider network of a Community Access Program (CAP), HEA also screens the applicant for CAP eligibility. If the applicant qualifies and chooses to enroll, the application assistor can collect the CAP enrollment fee and enroll the applicant in the discount program. In addition, HEA calculates the family's percentage of the Federal Poverty Level to enable community clinics to immediately enroll applicants into their own sliding-fee scale programs and determine the family's payment.	X	X	X	X

ACCOMPLISHMENT	STRATEGIC ISSUE(S) SUPPORTED BY ACCOMPLISHMENT			
	COSTS	QUALITY	UNINSURED	ORG. CAPACITY
Using HEA, subscriber organizations guarantee that applications and required documents are submitted to the state, receive contact information for the state worker processing the application, continue to work with the family to encourage a positive outcome, and receive the state's final determination. State agencies benefit by receiving legible, edited data, fully completed applications, required documentation, fewer interviews and faster feedback to application assistors and applicants.	X	X	X	X
Virtual Office Expansion: AHCCCS expanded its Virtual Office (VO) program. No longer a pilot program, VO opportunities exist in the Division of Fee for Service Management, the Information Services Division, the Division of Health Care Management, and the Division of Member Services. Since July 2005, AHCCCS has transitioned more than 300 employees, or 20% of the workforce, to full-time at-home employees. As a result of these efforts, AHCCCS ended its lease on two office buildings, including one in December 2007. Estimated annual savings from the first office closure is approximately $400,000 and from the second is $277,000. Additionally, minimum productivity increases range from 10% to over 45%. The advantages of working from remote telecommuting sites will continue to be assessed for further expansion. It is expected that in addition to high employee satisfaction and increased productivity, AHCCCS may be able to further reduce the number of offices needed statewide and, therefore, reduce overhead costs. In addition, it is expected that expansion of VO may enhance the candidate pool by allowing people with limited hours or mobility to join the workforce from home. Virtual Office also expands the worker pool to include rural locations that may be distant from AHCCCS worksites. For many of the lower level entry positions, the use of VO may help to reduce the turnover rate and attract a stable workforce by allowing more flexible work hours and reducing commuting costs. When termination ratios are compared, findings are dramatic: among VO staff, the termination ratio is 0.5 per 100 filled positions; among non-VO staff, the ratio is 1.5 per 100 filled positions. Thus, VO staff turnover is three times less frequent than non-VO staff turnover.	X			X
Field Office Space Reductions: During 2008, two Phoenix field offices were closed; the Tucson office was relocated, reducing space by 60%; and suites in both the Glendale and Mesa offices were vacated.	X			X

ACCOMPLISHMENT	STRATEGIC ISSUE(S) SUPPORTED BY ACCOMPLISHMENT			
	COSTS	QUALITY	UNINSURED	ORG. CAPACITY
Imaging System: An imaging system enables the electronic storage and retrieval of records previously available only in hardcopy. AHCCCS expanded its imaging capabilities throughout many areas of the agency, reducing costs associated with filing, storage, and retrieval of documents, and creating more efficient processes by streamlining the flow of work among multiple offices. It improves customer service by making documents available at other locations, while also enhancing document security.	X	X		X
Public Assistance Reporting Information System (PARIS) Grant: This newly-implemented system allows AHCCCS and DES to maintain program integrity and detect and deter improper public assistance payments. Both agencies are now able to share demographic information with other states to increase accuracy in eligibility determinations for public assistance programs (i.e., TANF, Food Stamps, and Medicaid), thereby decreasing the potential for improper payments from state and federal tax dollars.	X			X
Business Continuity: AHCCCS developed a new *e*-learning module that describes and augments how the agency will protect its staff, facilities, equipment, and records that support its essential functions. Additional drills and staff training in concert with the Department of Homeland Security and state agencies have allowed AHCCCS to further enhance its existing plan and capabilities.		X		X
Health-e-Arizona for Public Access: In mid-December 2008, AHCCCS and DES implemented a public access version of the Health-e-Arizona system. This is a web-based system that facilitates online screening of the public who wish to apply for Medicaid, KidsCare, Food Stamps, TANF, and/or Medicare savings programs. Applicants establish an account with a login name and password and submit the electronic equivalent of their signature along with the application. Applicants can fax documentation and electronically associate it with the application and signature.	X	X	X	X
MyAHCCCS.com Expansion: The AHCCCS member website now has over 60,000 registered accounts. Members can pay premiums, make an annual enrollment choice, and confirm the status of their eligibility and enrollment with a health plan. The availability of online transactions also benefits providers, health plans, other agencies, and internal staff.	X	X	X	X

ACCOMPLISHMENT	STRATEGIC ISSUE(S) SUPPORTED BY ACCOMPLISHMENT			
	COSTS	QUALITY	UNINSURED	ORG. CAPACITY
Employer Sponsored Insurance (ESI): As mandated by CMS as a special term and condition of AHCCCS's 1115 waiver, AHCCCS implemented an Employer Sponsored Insurance selection option in December 2008. Children eligible for KidsCare can now be covered under a parent's employer sponsored insurance plan and AHCCCS will reimburse up to $100 per eligible child, not to exceed the actual cost of the premium. AHCCCS will not be responsible for any cost-sharing requirements of an employer-sponsored plan.	X	X	X	X
Medicaid in ACE: In February 2009, the AHCCCS Customer Eligibility (ACE) system will promote and enhancement to help in the processing of Medicaid eligibility determinations related to combined applications for both KidsCare and Medicaid. It is expected that this will reduce the time it takes to complete the overall application process (as well as applicant confusion), reduce the transfer of applications for Medicaid that currently go to DES, and reduce discontinuances of benefits related to processing differences between AHCCCS and DES.	X	X	X	X
DMS Network Café: In November 2008, AHCCCS implemented the Network Café in one of its key divisions—the Division of Member Services (DMS). The Network Café is an effort to train DMS staff in the use of available electronic tools (web conferencing, e-learning, blogs, etc.) and to build opportunities for training, conferencing, networking, and communication between employees. This will significantly reduce the need for face-to-face training sessions, meetings, conferences, and other travel-related communication efforts.	X			X
Customer Service Representative Test: Development of the Customer Service Representative (CSR) test was completed in August 2008. The test evaluates an applicant's reading comprehension, customer service knowledge, work ethic, and skills in spelling and grammar. Currently, collaborative work is underway to make the test electronic, including an audio component whereby the applicant hears a mock phone call and then selects the appropriate response from multiple possibilities. Full implementation is planned for the first quarter of 2009.		X		X
E-learning expansion: AHCCCS continues to be a leader among state agencies in e-learning design and development. AHCCCS created an agency plan for upgrade to iLinc version 10, including coordination of communication and training. AHCCCS has already converted several training modules from the classroom environment to an e-learning environment, and several more modules are in the process of being converted.	X			X

TOTAL RESOURCES and ASSUMPTIONS

Membership and Financial Projections

AHCCCS health plan weighted average capitation rates increased 7.3% for Contract Year 2009. As the largest health insurer in Arizona, with over one million members, AHCCCS expects some leverage to secure discounts and competitive rates. Because of the size and scope of the program, AHCCCS plays a key role in the local health care market in terms of volume and rate setting. Careful attention is needed to ensure equitable resource distribution through rate setting and negotiations.

The following table presents total AHCCCS budget estimates with associated assumptions:

Total SFY09 – SFY14

	SFY09 Approp.	SFY10 Budget Submittal	SFY11 Estimate	SFY12 Estimate	SFY13 Estimate	SFY14 Estimate
Full Time Equivalent (FTE)*	3,201.4	3,228.4	3,228.4	3,228.4	3,228.4	3,228.4
General Fund	1,425,272,300	1,678,716,200	1,871,634,300	2,078,969,300	2,306,010,100	2,554,642,100
Other Appropriated Fund	292,981,900	252,092,600	262,642,400	278,084,200	294,975,500	313,454,400
Non-Appropriated Fund	477,075,000	493,092,000	514,016,000	536,946,300	562,075,300	589,613,800
Federal Funds	4,050,836,000	4,419,103,600	4,835,323,400	5,291,264,600	5,790,731,500	6,337,892,500
TOTAL FUNDS	$ 6,246,165,200	$ 6,843,004,400	$ 7,483,616,100	$ 8,185,264,400	$ 8,953,792,400	$ 9,795,602,800

*FTEs include appropriated positions for or associated with ADES Eligibility pass-through funding.

RESOURCE ASSUMPTIONS
Fiscal Year 2010 – Fiscal Year 2014

Dollars are shown in thousands:

All Strategic Issues	SFY10
FTE	27.0
General Funds	$ 3,139,700
Other Appropriated Funds	398,100
Non-Appropriated Funds	0
Federal Funds	4,560,500
Total Funds	**$ 8,098,300**

Notes:

(1) The only Resource Assumptions included as part of this strategic issue are those that represent either new program services or administrative additions to existing programs. These are included in the agency's annual Budget Request as critical issues or decision packages.

(2) Future fiscal years are not shown as the agency is required to submit budget requests annually.

Growth Assumptions:

Growth for FY10 mirrors the FY10 budget submittal by program.

Growth for FY11 – FY14 is based on the following population and rate increase assumptions:

- Member growth is based on anticipated 2.9% Arizona population growth as provided by the University of Arizona study in the October 2008 issue of *Arizona's Economy*.
- Rate growth assumes an overall average inflation of 6.5% per year.
- All growth assumptions are based on current AHCCCS service and population model. The state's budget shortfall for FY09 and FY10 may result in changes to this model, which would alter growth in future years.

Other Notes:

- Administrative costs are increased at a rate of 2.5% annually, and assume a federal match and fund split equal to the 2010 request. At this point, no additional FTEs are added for 2011-2014. Given the state budget shortfall, it is more likely that there will be FTEs cut in the short term.
- KidsCare and HIFA parents programs are assumed to continue through 2014. This assumption is dependant upon the federal reauthorization of SCHIP and the resulting Arizona SCHIP allotments.
- The amounts included in this report represent the AHCCCS appropriated budget only and do not include DHS pass-through funding for behavioral health and CRS, DES pass-through funding for DD LTC, School Based Services, or Healthcare Group Programmatic funding.
- Assumes the FFY10 projected FMAP of 65.75% (76.03% enhanced) will continue through 2014.
- The starting point is the FY 2009 JLBC appropriations report and does not include any potential surplus/supplemental.
- Assumes that Tobacco Funding will remain constant at the FY 2009 appropriated level. Any reduction to Tobacco funding would require additional General Fund.

POPULATION INITIATIVE: Responding to a Growing Aging Population

For the first time in this country's history, the older population is growing faster than the general population. The baby boom generation, which includes individuals born between 1946 and 1964, is twice the size of its preceding generation and 50% the size of its succeeding generation. Between 2011 and 2020 these baby boomers will turn 65, creating the most dramatic age shift in history and straining government resources and health system capacities. Because of its sheer numbers and percentage growth, this cohort is likely to overwhelm the traditional responses of the family, the private sector, and the government. The increased need for long term care may outpace the supply, and the costs of health care and social services may extend beyond the reach of most elderly. Arizona, like the rest of the nation, will face the challenges of creating a safety net for an aging population in an environment in which taxpayers are proportionately decreasing. The good news is there is still time to plan and prepare for these significant changes. AHCCCS is committed to assuming a leadership role toward that end.

"For the first time in this country's history, the older population is growing faster than the general population."

Environmental Scan

In addition to nationwide studies and census data, two major Arizona-specific endeavors provide a wealth of information useful in the assessment and understanding of an aging society. In the spring of 2002, Saint Luke's Health Initiatives completed *The Coming of Age*, a major research report on the status of aging in Arizona, particularly as it impacts future health care. In the spring of 2004, the Governor issued an Executive Order directing state agencies to develop plans to address the needs of the state's rapidly growing population of senior citizens. To date, these plans have been drafted and compiled and, following community input, will be finalized to form Arizona's *Aging 2020* initiative. Collectively, these resources offer a comprehensive picture of the senior population that is an imminent challenge to our health care system.

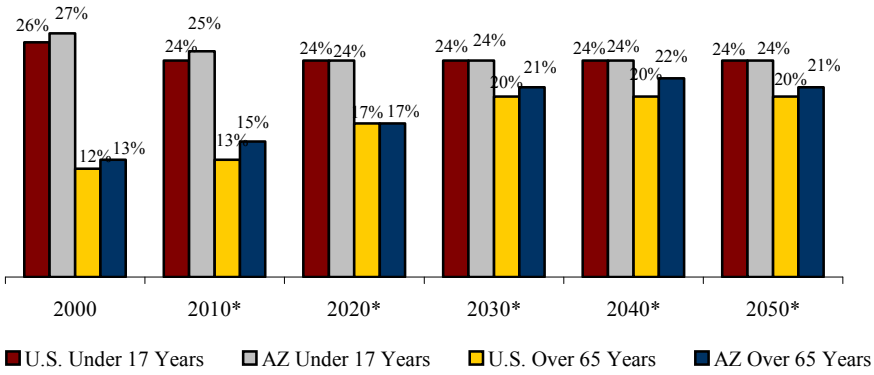
Demographics

Age

Population growth is based on measures of births, deaths, and migration. Similar to the national average, Arizona seniors, 65 years of age and older (≥65), currently account for approximately 13% of the state's total population, whereas Arizona residents 17 years of age and younger (≤17) currently account for approximately 26%. By 2025, however, the percentage of seniors ≥65 years is projected to increase to approximately 20%, whereas the percentage of residents ≤17

years is expected to decline slightly to approximately 24%, reducing the ratio of caregivers to care recipients. Between 2000 and 2025, Arizona's growth of seniors ≥65 is projected to rank ninth in the nation.

Age-Specific Populations in Arizona and United States, 2000-2050*

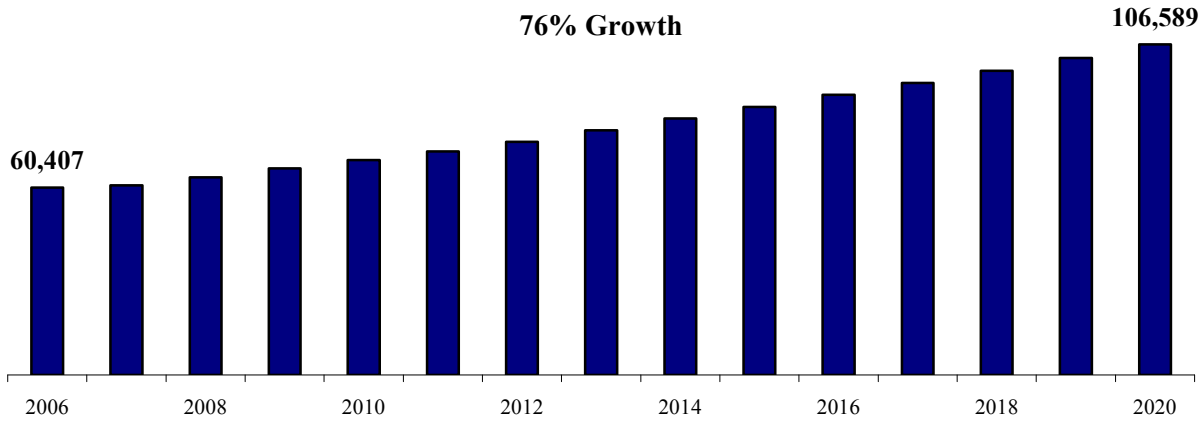


* Projected

Source: Arizona Health Futures

Individuals who move into Arizona, including the elderly, have played a major role in the state's population growth. Although the elderly comprise a relatively small proportion of this group, they tend to remain in place once they arrive. In fact, it is estimated that approximately one-half of the state's retirement age residents moved here after age 55.

Projected Number of AHCCCS Members (Ages 65+)



Sources: Arizona Department of Economic Security Projections by Age and AHCCCS Enrollment by Age.
Assumption: AHCCCS enrollment growth will increase for this age group in proportion with the increase in Arizona population for this age group.

The figure above illustrates the current AHCCCS population age 65 and older, and its potential for growth. Assuming AHCCCS growth is proportionate to that projected statewide, the volume of members age 65+ could increase approximately 76% by 2020.

Geographical Distribution and Growth

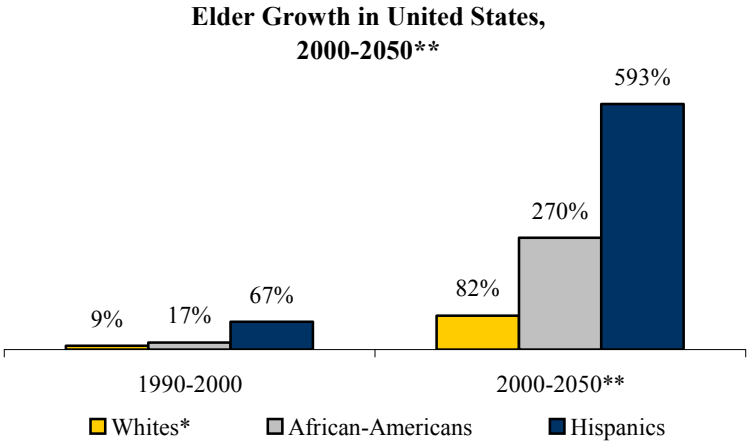
AGE 65+ POPULATION BY COUNTY						
County	Year 2000		Year 2020*		Year 2050*	
	Number	Percent	Number	Percent	Number	Percent
Apache	5,762	8%	11,354	13%	16,800	16%
Cochise	17,310	15%	37,619	22%	53,822	25%
Coconino	8,142	7%	21,230	13%	31,160	16%
Gila	10,164	20%	18,033	28%	24,175	31%
Graham	3,985	12%	6,740	16%	10,019	20%
Greenlee	846	10%	1,070	13%	1,262	14%
La Paz	5,086	26%	10,780	42%	14,510	47%
Maricopa	359,441	12%	764,055	15%	1,372,593	18%
Mohave	31,782	21%	82,747	29%	129,612	32%
Navajo	9,747	10%	24,351	17%	36,865	19%
Pima	119,812	14%	243,375	19%	391,309	23%
Pinal	29,116	16%	152,498	25%	369,766	28%
Santa Cruz	4,107	11%	9,854	16%	15,906	19%
Yavapai	36,854	22%	91,753	30%	142,095	34%

*Projected Source: AZ Department of Economic Security

The majority of Arizona residents live in Maricopa or Pima Counties, where most of the state's senior population growth is expected to take place. Nevertheless, as indicated above, a number of rural areas such as Gila, LaPaz, Mohave, and Yavapai Counties, are home to a higher proportion of elderly than the two urban counties. It is especially important to consider the magnitude of prospected age shifts by county. La Paz County, a primarily rural area just north of Yuma County, serves as a good example. The expected shift in percentage of elderly from 26% in 2000 to 42% in 2020 is the state's highest, and the dramatic increase in the elderly population proportion over time could significantly impact the local infrastructure. Attracting the elderly here are affordable housing; moderate temperatures, especially in winter; and close vicinity to California, Mexico, the Colorado River, and numerous recreational areas.

This is an important consideration, particularly since the majority of these rural elderly are expected to age in place. At the same time existing rural populations are aging, marketing efforts attempt to attract new retirees in an effort to further economic development. These two forces combine to create significant population changes. Moreover, over one-third of AHCCCS members age 65 and older reside in the state's rural communities. It is presumed that older individuals will continue to account for over one-third of rural residents. This reinforces the importance of planning for rural as well as urban populations.

Ethnicity



* Non-Hispanic. **Projected.
Source: Arizona Health Futures

According to national data, Hispanics accounted for the largest population growth (67%) between 1990 and 2000. This pattern is expected to continue until 2050, when the percentage growth of Hispanics is estimated to reach 593% nationwide.

Whereas the majority of today's elderly Arizonan's are white, tomorrow's elderly will be notably more diverse. In particular, growth among Hispanics is expected to outpace other groups, particularly in Arizona where, according to Kaiser, the Hispanic percentage of the state's population in 2007 (30%) is already notably higher than the national average (15%). Furthermore, the most recent census data shows that Arizona experienced a 45% increase in its Hispanic population between 2000 and 2007 compared with 29% Hispanic growth nationally.

Historically, the Hispanic population has tended to be "younger" than the non-Hispanic white population. Recent data, however, indicate that the median age has risen over the past decade, reinforcing the importance of cultural competence when planning responses to an aging population.

While Hispanics currently account for 30% of the state population, they account for 46% of AHCCCS members. Assuming that future AHCCCS ethnicity changes are consistent with those projected statewide, Hispanics could represent an even greater percentage of the 65+ AHCCCS membership in the future.

The Arizona American Indian and Alaska Native (AI/AN) population, which currently accounts for 5% of the state total, is projected to remain stable. AI/AN currently account for 11% of enrolled members. Sensitivity to factors such as culture and language, especially in older individuals, has significant implications for patient compliance and reduction of health disparities.

Health Status

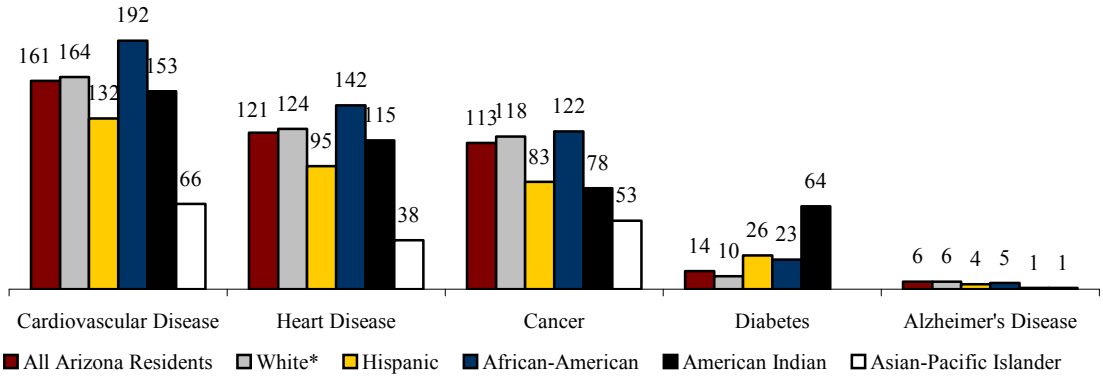
Americans will live longer in the 21st century than in any previous generation. The fact remains, however, that along with aging comes an increase in the number of individuals living with one or, frequently, more than one chronic condition. The growing number of those with chronic conditions will be seeking care in a system that is accustomed to delivering uncoordinated services to individuals with immediate acute needs. It is not a system that has ample networks of care or experience coordinating care across a service continuum for people with multiple chronic conditions.

Estimates indicate that, in 1996, 99 million people in the United States suffered from chronic conditions. By 2002, those numbers increased to more than 125 million, or nearly half of all Americans. By 2020, as the population ages, this number will increase, and many will have multiple conditions that cause functional limitations and disabilities. Recent estimates are that nearly half of all people with chronic conditions have multiple chronic conditions. By 2020, it is estimated that 81 million will have two or more chronic conditions and at least 25% of this number will have activity limitations.

In some respects, Arizonans may be healthier than residents of other states (e.g., the death rate is less than for the nation as a whole). Many other indicators, however, deserve attention, particularly as they impact the health of the elderly. According to ADHS, arthritis and high blood pressure affect elders most often, and a growing problem of obesity impacts both of these conditions. Also, up to 25% of older Arizonans may suffer from mental health problems, commonly depression and anxiety.

An important demographic concern regards the differences in medical conditions among the state's racial and ethnic groups. A better understanding of these differences lends insight to the variety of health needs among the elderly and, in addition, provides an opportunity to address concerns proactively.

Deaths per 100,000 in Arizona, 1999



*Non-Hispanic.
Source: Arizona Health Futures

The figure above presents death rates by disease type and ethnicity. It seems clear that, as the population ages and becomes more diverse, there are increasing opportunities for health care providers to develop tailored disease management programs. For example, the education and management of elderly American Indians with diabetes calls for unique programming strategies.

Caregiver Resources

The aging population will bring with it increased needs for medical care delivery, particularly long term care services and support systems. Over the next 15 years, the number of people who need long-term care is expected to increase by 30%. After that, the number will increase even

more dramatically until 2050, when the number of people with long term care needs is estimated to double. This concern is compounded by the fact that, at a time when the number of people needing long term care is likely to increase substantially, the overall labor force relative to the size of the population is likely to be smaller than it is today. This affects both formal e.g., professional) and informal (e.g., family) health care resources.

Currently, Arizona has over 1,500 hospitals, clinics, nursing homes, and assisted living facilities, the majority of which are located in Maricopa and Pima Counties, the current state population centers. This is problematic given the anticipated needs of the over one-third of the state's elderly who reside in rural communities.

Multiple factors affect formal health care resources. In particular, liability insurance costs for nursing home facilities and physicians have risen dramatically. These rapidly increasing costs are a major challenge, especially for smaller providers serving the elderly in rural communities.

It is significant that Arizona has comparatively fewer doctors and nurses per 100,000 population than is found nationwide. In addition, it is a relatively unstable workforce, as the turnover is significant and the average tenure is short. The issues are similar among non-professional caregivers, who describe demanding conditions and, often, inadequate compensation. It is important to remember that aging is an issue for workers as well as for recipients of service. An increasing number of health professionals will soon age out of the workforce.

Multiple factors also affect informal health care resources. The percentage of elderly needing care is outpacing the percentage of younger individuals capable of providing that care. Families are decreasing in size, and adult children pressed into service are likely to have fewer siblings to turn to for respite. Increased mobility also increases the likelihood that children live farther away from their parents. Dual-income families leave neither spouse available to provide full-time care. In addition, people are living longer; lengthening the time that care may be required.

All of these factors have an impact on informal caregivers as well, as they juggle a myriad of financial, physical, emotional, and medical responsibilities. Ultimately, this may place a greater burden on formal caregivers, whose numbers are already insufficient to meet current needs.

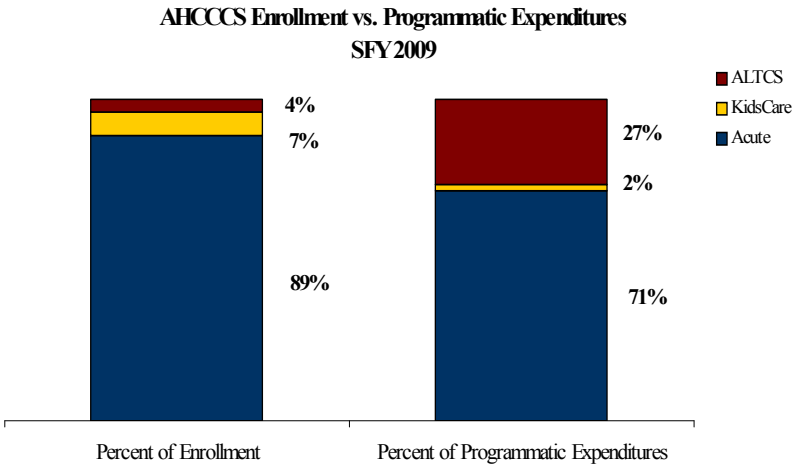
Significance to AHCCCS

From its inception in 1982 until 1988, AHCCCS covered services to an acute care population only. In November 1988, the program was expanded to include the Arizona Long Term Care System (ALTCS) for elderly and physically disabled (EPD) and developmentally disabled (DD) populations. Based on their health status, members age 65 and older may be enrolled in either the acute or long term care program. The majority qualify for Medicare benefits. However, because of their income status, they depend on AHCCCS or ALTCS for cost-sharing and critical services uncovered by Medicare.

Unlike programs in other states that rely solely on fee-for-service reimbursement, AHCCCS provides prospective payments to AHCCCS-contracted health plans and ALTCS program

contractors. The result is a managed care system that mainstreams recipients, allows them to choose their providers, and promotes the coordination of quality care across all age groups.

Whereas ALTCS members account for only 4% of the over one million AHCCCS enrollees, they account for approximately 27% of total AHCCCS expenditures. Thus it is important that Arizona, one of the fastest growing states in the nation, prepare for an aging population through innovative, sensitive, and cost-effective programs



*Excludes HCG and Medicare Cost Sharing Programs.

In its role as the Medicaid provider to both acute and long term care populations, AHCCCS is uniquely positioned to provide an entire continuum of services and settings that impact an aging population. Programs that promote health and emphasize the prevention and management of chronic diseases ensure efficient use of public resources and create a positive difference in the quality of life for aging Arizonans. A range of settings and services that offers flexibility and favorable alternatives to institutionalization is equally important.

Key Issues and Current Responses

As the provider of acute and long term health care coverage to approximately 18% of the Arizona population, AHCCCS must address some key issues vital to changing demographics, particularly as they affect an aging population. The issues both impact and are impacted by this strategic plan, which establishes a commitment to: (1) control medical cost inflation, (2) improve health care quality and accessibility, (3) reduce the volume of uninsured, and (4) enhance organizational capacity. These four imperatives guide current and future policy and program responses to the demographic aging issues identified above.

Costs and Funding

In a climate of steadily rising health care costs and limited funding, the economic consequences of demographic aging present a critical challenge. As the percentage of seniors increases, the per capita cost of health care is likely to increase. Present state and federal funding sources for Medicare and Medicaid may prove to be structurally insufficient to support these changing demographics. Both long term financing reform and fiscal responsibility emerge as major considerations in addressing care for an older population. Medicaid is currently the primary source of long-term insurance coverage for the elderly and disabled, including middle-income

individuals who exhaust their assets as a result of long term care. Funding these services places considerable burdens upon state Medicaid budgets.

- ALTCS takes advantage of federal waiver opportunities to offer a flexible long term care system, and has established principles, programs and payment strategies that encourage and support the delivery of cost-effective, quality services in the least restrictive settings.

- Currently, approximately 67% of the ALTCS elderly and physically disabled populations reside outside an institutional nursing facility. The cost to provide services to an individual in his/her own home or community is approximately one-third the cost of a nursing facility bed, and survey research indicates that older adults overwhelmingly prefer to remain in their own homes as long as practical. ALTCS covers an extensive range of home and community-based services (HCBS), and has continued to explore and expand coverage of additional types of assisted living facilities that allow members alternatives to institutionalization.

- An estimated 20% of Arizonans lack health insurance. Efforts to reduce the uninsured population in Arizona are vital to ensuring accessibility to care and, ultimately, maintaining the health of an aging population in a cost-effective manner. AHCCCS administers Healthcare Group, which offers affordable premium based insurance to small businesses. Over 41% of small business employees and related members covered by HCG are age 50 and older. This is a group that often has difficulty obtaining affordable coverage.

Unique Health Care Needs

As explained above, an aging population means an increase in the number of individuals living with one or more chronic conditions and seeking care in a system that is, in large part, structured to respond to acute care needs. AHCCCS is challenged to respond proactively by supporting preventive measures and coordinating quality care and disease management for members of all ages, throughout all programs, and across an entire continuum of services.

- A critical response to demographic aging and its accompanying chronic care burden is the prevention or early recognition and management of disease and disability in individuals of all ages. AHCCCS covers annual wellness examinations and screening procedures for an array of diseases (e.g., cervical cancer, prostate cancer) and offers multiple health education programs (e.g., nutrition, smoking cessation) designed to encourage healthy lifestyles at all ages.

- To facilitate the earliest possible identification of members who may benefit from care coordination, disease management, or some other population-specific assistance, AHCCCS requires contracted health plans to conduct health risk assessments on all new members.

- AHCCCS places significant importance on immunizations, including influenza and pneumonia immunizations for adults. Tracking and outreach is particularly important in light of recent data suggesting that flu and pneumonia immunizations for frail adults contribute to decreases in illnesses, hospitalizations, and nursing facility admissions.

- A total of 10 AHCCCS plans have Medicare Advantage plans. Some qualify as full Medicare Advantage Plans that focus on individuals with special needs, such as those who are eligible for both Medicare and Medicaid (dual-eligible members). As such, these plans are in a position to coordinate a member's care more effectively.

Availability and Accessibility of Care

Changing demographics will only magnify current issues related to the availability and accessibility of health care. Because the elderly have an increased need for health care services, and because the number of formal and informal health care providers could be inadequate to meet the need, the healthcare workforce must increase in greater proportion than the overall 65% growth projected for Arizona's senior population. This presents a challenge since Arizona currently claims fewer doctors and nurses than the national average, and paraprofessionals are seeking alternative jobs that offer greater satisfaction and salaries. Family caregivers, who previously assumed the bulk of care for their elders are also aging and may be unable to continue in caregiver roles without additional support. Future strategies must address barriers to the adequacy of both workforce and settings.

Geographical concerns add another dimension to issues of accessibility. Although a majority of Arizona's older population resides in urban counties (i.e., Maricopa and Pima), a number of rural counties include a greater proportion of elderly residents than urban counties. Approximately one-third of the population age 65 and older resides outside primarily urban areas. This rural population is likely to increase, challenging AHCCCS to assess new strategies to support the growth of local health care infrastructures and evaluate emerging technological opportunities such as telemedicine.

- ALTCS contractors are required to submit an Annual Network Development and Management Plan that analyzes the current status of their networks, identifies gaps and delays in service, and describes strategies for improvement. These plans promote the identification of issues and potential solutions to meet the needs of members. In addition, ALTCS contractors use member-provider councils to represent respective stakeholder communities. Council member feedback assists contractors in identifying unmet needs.

- The most recent AHCCCS contract with ALTCS program contractors specifically encourages them to participate in the development of a direct caregiver workforce. Because program contractors constitute the largest payer group for paraprofessionals in the long term care market, they must leverage this to ensure adequate resources in the future. The program contractors must have, as part of their network development plan, a component regarding paraprofessional work force development in nursing facilities, alternative residential facilities and in-home care situations. Workforce development includes actions related to the active recruitment and pre-employment training of new caregivers and opportunities for continued training of current caregivers. It also includes efforts to review compensation and benefit incentives.

- In support of workforce development, AHCCCS was awarded a grant entitled "Direct Service Workforce Development Intensive Technical Assistance to States," sponsored by

CMS. Arizona was one of five states selected to receive technical assistance throughout 2007. The grant provided assistance to the ALTCS program to ensure the availability of direct service workers to provide home and community based services. Expert staff from the CMS Direct Service Workforce Resource Center will assisted the state in developing policies, support mechanisms, monitoring mechanisms, and evaluation tools related to consumer-directed care and reimbursement of spouses as paid caregivers. The Governor's Citizens Workgroup on the Arizona Long Term Care Workforce Report, issued in April 2005, identified these as two key strategies for ensuring a sufficient and capable workforce.

- ALTCS currently pays for services rendered by family members. Today, approximately one-half of all paid caregivers are family members. Sustaining that percentage is critical to the maintenance of an adequate caregiver force.

- Because the burden on care-giving spouses may extend far beyond ordinary obligations and contribute to job loss and financial burdens, AHCCCS sought and received a federal waiver that allows spouses to be eligible for reimbursement for care-giving activities. To ensure integrity of this process, the paid spousal care-givers must meet established criteria and the services they provide must be monitored regularly.

- AHCCCS is a major participant in a variety of councils and work groups, including the Interagency Council on Long Term Care, the Governor's Council on Aging, and the Governor's Citizen's Work Group on the Long Term Care Workforce. With the support of multiple stakeholders, these collaborations identify gaps in services and facilitate mutual improvement efforts.

- Behavioral health services are a necessary component of care for a significant number of ALTCS members. Effective coordination of behavioral and medical case management reduces costs by facilitating more timely discharges from acute facilities and more appropriate use of community resources.

Ethnic Diversity

Older Arizonans may be more diverse in their ethnicity and their health needs. Currently, Hispanics account for 30% of the state population but 46% of the AHCCCS population. American Indians and Alaska Natives account for 5% of the state population but 11% of the AHCCCS population. Sensitivity to factors such as culture and language, especially in older individuals, has a significant impact on patient compliance and health care disparities.

- AHCCCS requires contracted health plans to address cultural competency education and concerns about its network.

- AHCCCS supports a comprehensive diabetes management program that is especially important to American Indians who have a high incidence of the disease.

AHCCCS Organizational Capacity

The AHCCCS workforce is not immune to an aging demographic, and serves as an example of the challenges confronting the community-at-large. Without attention to employee recruitment, retention, and succession planning, the estimated growth in employee attrition will significantly impact the agency's ability to fulfill its mission. AHCCCS employed 1,288 employees in SFY 2008. Current analyses indicate 9.1% of the agency's active employees will be eligible for retirement by 2009, and 24.3% will reach retirement age by the year 2013. This rate is may be increased by non-retirement issues.

Recommended Strategies

The previous section described current AHCCCS endeavors that affect a variety of issues related to a growing aging population. This section summarizes additional strategies important to AHCCCS as it prepares for the approaching age shift. More detailed information regarding these strategies may be found in two additional documents: (1) The Aging Plan developed by ALTCS to guide and support long range planning for long term care, and (2) The AHCCCS response to Aging 2020, the Governor's state aging initiative.

Consider Demographic Aging in the Development of Health Care Quality Improvement Processes and Benefit Designs

- Identify and expand culturally competent health education opportunities for individuals of all ages and promote wellness throughout the aging process. In particular, focus on obesity, which has definite consequences for an aging population, increasing the risks involved with such diseases as arthritis, diabetes and hypertension.

- Cooperate and collaborate with ADHS to enhance outreach efforts and improve participation in preventive services (e.g., obesity programs, adult immunizations).

- Support "universal building" efforts extended by the Department of Housing. Universal building requirements impact senior safety and eliminate the need for future AHCCCS coverage of structural revisions (e.g., rails, ramps).

- Investigate alternatives for financing currently uncovered services that are vital to senior independence and quality of life, specifically vision, hearing, and dental services. These services, which are not currently covered by Medicare or Medicaid, can be significant determinants of senior independence.

- Coordinate the development and implementation of evidence-based practice guidelines for chronic diseases and identify centers of excellence as well as providers with exceptionally good outcomes.

Prepare an Adequate and Appropriate Delivery Network

- Ensure the stability of nursing home facilities, hospitals and other critical providers through equitable reimbursement rates, and the support of efforts that address unsustainable malpractice premiums.

- Investigate opportunities to facilitate provider recruitment and retention efforts, particularly in underserved areas, by (1) supporting the infrastructure of Federally Qualified Health Centers (FQHCs) and other existing providers (including direct caregivers), (2) cooperating with state medical schools to support professional training programs that produce gerontological specialists and fill gaps in medical service availability, (3) expanding the use of physician extenders (i.e., nurse practitioners and physician assistants), and (4) developing more informal and community resources to improve the continuum of care.

- Evaluate the return on investment resulting from a "Transitional Service." This service would provide Medicaid dollars to assist with a member's transition from an institutional setting to a less-costly in-home setting. Funding may assist members with rental deposits, utilities payments, and household start-up costs, ultimately facilitating transition from an institutional setting to HCBS.

- Ensure the continuance of incentives that promote the use of cost-effective HCBS placements without compromising quality of care.

- Facilitate and support caregiver education through collaborative partnerships, and ensure ongoing access to useful caregiver resources.

- Improve accessibility to care by investigating opportunities to enhance medically necessary transportation services.

Maximize Use of Information and Technology

- Enhance information systems to improve the ability to collect and analyze pertinent data, particularly related to senior health issues. Assess the feasibility of developing a cost-effective information system that is capable of integrating data from multiple sources (e.g., eligibility assessments, health service encounters, pharmacy encounters, case management evaluations, and care plans) for the purpose of enhancing Case Management, Assessment, and Planning (CMAP) activities.

- Review and enhance the AHCCCS website to ensure its suitability for an aging population (e.g., large font options, user-friendly directions, adaptations for disabilities), and recognize that the web may provide many applications in the future that do not exist today.

- Evaluate the efficiency, effectiveness, and cost-benefit of technological advancements that allow individuals to remain safely in their homes (e.g., assistive devices, medical monitoring, and telemedicine).

POPULATION INITIATIVE: American Indian Health Care

Arizona is home to approximately 277,732 American Indians and Alaska Natives (AI/AN), nearly half of whom are enrolled in AHCCCS. Whereas the AI/AN population accounts for only 5% of the total state population, it accounts for 11% of the Arizona Health Care Cost Containment System (AHCCCS) population. Historically, the burden of illness among AI/AN has been significantly greater than that of the general population. The nature and scope of AI/AN health disparities has been attributed to a variety of issues that include social and cultural barriers, legislative and financial concerns, and persistent structural problems. For example, the actual delivery and documentation of AI/AN health services is frequently divided between multiple providers, fragmenting the continuum of care and disrupting the flow of important health information. AHCCCS faces significant challenges in its role as a major source of health care services to AI/AN populations and is committed to developing and implementing strategies that ultimately lead to improvements in health status.

"Arizona is home to approximately 277,732 AI/AN, nearly half of whom are enrolled in AHCCCS."

Environmental Scan

Demographics

Population

American Indian & Alaska Native Population Distribution:
US vs. Arizona vs. AHCCCS (2007 Estimates)

Race	United States		Arizona		AHCCCS	
	Number	Percent	Number	Percent	Number	Percent
AI/AN	2,938,436	1%	297,422	5%	132,157	10%
Non-AI/AN	298,682,721	99%	6,041,333	95%	1,158,674	90%
Total	301,621,157	100%	6,338,755	100%	1,290,831	100%

Arizona has the seventh largest AI/AN population in the nation. Whereas AI/AN account for approximately 1% of the United States population, they account for approximately 5% of the Arizona population and 11% of the AHCCCS member population. As nearly one-half of the state's American Indians and Alaska Natives are enrolled in AHCCCS, opportunities exist for the agency to promote policies and deliver health care that positively impacts the future of this population.

Age

General and AI/AN Populations by Age: US vs. Arizona vs. AHCCCS

Age	United States		Arizona		AHCCCS	
	General	AI/AN	General	AI/AN	General	AI/AN
<21	30%	38%	31%	44%	56%	55%
21-64	58%	56%	56%	50%	38%	40%
>64	12%	6%	13%	6%	6%	5%
Total	100%	100%	100%	100%	100%	100%

The above table demonstrates that the age distribution of AI/AN in Arizona is reasonably similar to that of AI/AN across the nation. When AI/AN are compared with the total general population (AI/AN and non-AI/AN), however, they include a substantially higher percentage of children and a substantially lower percentage of older adults. The higher percentage of children, evident across national, state, and AHCCCS data, is consistent with a projected 40% growth in the AI/AN population between 2000 and 2025. This is compared to a projected growth in the total population of 23%. The lower percentage of older adults is consistent with data indicating that AI/AN live almost eight years less than the total population.

Geographical Location

American Indians and Alaska Natives contribute significantly to Arizona's cultural diversity. The state is home to 22 federally recognized American Indian tribes. American Indians and Alaska Natives live in both urban and rural areas. Approximately 58% of AI/AN AHCCCS members reside on reservations, which comprises approximately one quarter of Arizona land. Reservations are primarily rural and expansive in geography. Many reservation communities are isolated and have limited resources in regards to forms of transportation, communication, health care, internet access, and public utilities.

Economic Status

Economic Characteristics: US vs. AZ: General Population vs. AI/AN Population

Characteristic	United States		Arizona	
	General Pop	AI/AN Pop	General Pop	AI/AN Pop
Median Household Income	$41,994	$30,693	$40,558	$24,514
Below Federal Poverty Level	12%	26%	14%	36%

The above table demonstrates some disconcerting facts related to AI/AN economic status. According to national census data, Arizona AI/AN have lower household incomes and higher federal poverty levels than both national and statewide general populations. In addition, AI/AN in Arizona have lower incomes and higher poverty levels than fellow AI/AN nationwide. These factors contribute significantly to disparities in health status.

An erroneous assumption exists that since some American Indian tribes have begun to use gaming enterprises to stimulate their local economies, federal assistance is no longer necessary. This perception is inaccurate for several reasons. First, it ignores the federal trust obligation to provide health care to American Indian and Alaska Native members of federally-recognized tribes. Second, it exaggerates the amount and influence of gaming profits. In reality, approximately one-half of all tribes have casinos, and only a small number of those have been particularly successful. Many barely break even because of inadequate size or poor location, and much of the gain goes to non-Indian investors. Although some tribes have applied a portion of their increased revenue to health care, the majority continues to rely on Medicaid and funds appropriated to Indian Health Service (IHS).

Health Concerns

American Indians and Alaska Natives suffer disproportionately from a variety of conditions that not only affect overall health status, but impact economic, educational, and social development as well. Inadequate access to preventive and basic health care, poverty, remote geography, and alcohol and substance abuse continue to counteract the progress made in public health and health care delivery systems. Many of the chronic conditions which are prevalent in AI/AN communities can be attributed to various risk factors including individual lifestyle choices.

According to the Indian Health Service in a 2000-2001 report entitled, "Trends in Indian Health," (1) diseases of the heart, (2) malignant neoplasms, (3) unintentional injuries, (4) diabetes mellitus, and (5) chronic liver disease and cirrhosis were the five leading causes of death among AI/AN in the IHS Service Area from 1996-1998. Similar findings were reported by the Arizona Department of Health Services (ADHS) in a 2006 report entitled "Health Status Profile of American Indians in Arizona." In Arizona, the top five leading causes of death among American Indians in Arizona were (1) diseases of the heart, (2) unintentional injury, (3) cancer, (4) diabetes, (5) chronic liver disease and cirrhosis.

Diabetes

Diabetes mortality among AI/AN is 3.1 times higher than that among the general population in the U.S. The prevalence of the disease is 16.3% for AI/adults, compared with 8.7% of non-Hispanic whites. Data compiled from the IHS user population database (2005) indicated that 14.2% of AI/AN aged 20 years or older in the IHS service area had diagnosed diabetes.

About 16.5% of the total adult population served by IHS had diagnosed diabetes, with rates varying by region from 6.0% among Alaska Native adults to 29.3% among American Indian adults in southern Arizona. In fact, the highest incidence of diabetes in the world is found in the Tohono O'odham Nation in Arizona, with half of all adults having adult-onset diabetes. Among the AI/AN population with diabetes, 95% have Type II diabetes. Type II diabetes is a condition that is largely preventable with lifestyle changes. Changing agricultural conditions have led to crop reductions and reliance on commodity foods. According to the IHS, the average annual medical care cost of one individual with diabetes is $13,243, compared with $2,560 costs for one without diabetes.

AI/AN children have increasingly been affected by Type II diabetes. The following increases in prevalence in AI/AN were documented between 1990 and 2002 by age group: 132% (ages 25-34), 69% (ages 20-24), and 106% (ages 15-19). The frequency is increasing at a faster rate among AI/AN children and young adults than among any other ethnic population. IHS reports a 45% increase in the prevalence of diagnosed diabetes among all ages served by the Indian Health Service. The highest rate of increase has occurred among young adults aged 25-34 years, with a 132% increase between 1990 and 2004; during the same period, Type II diabetes rose 106% in youth between 15 and 19 years of age.

Cardiovascular Disease

Cardiovascular disease has increased dramatically among the American Indian and Alaska Native population in recent years. According to the IHS, heart disease has become the leading cause of death among AI/AN. AI/AN individuals have cardiovascular disease rates twice that of the general population. The risk of stroke among younger AI/AN individuals is reported to be as much as twice as high as all ethnic groups combined. These significant rates may be attributable, in part, to diabetes, hypertension, and risk behaviors including poor eating habits and sedentary lifestyles. In fact, 66% of AI/AN individuals with cardiovascular disease had diabetes first.

Mental Health Disorders

American Indians and Alaska Natives are at higher risk for mental health disorders than any other racial or ethnic group in the nation. The most significant current mental health problems include a high prevalence of depression, anxiety, violence, and suicide.

"Suicide is the second leading cause of death for AI/AN aged 10-34 years."

Depression in AI/AN, which has become a principal concern, is commonly associated with isolation, traumatic events, poverty, and hopelessness. Depression can pose as a major risk factor for suicide. High suicide rates among AI/AN individuals may be attributed, in part, to depression. Suicide is ranked as the eighth leading cause of death for AI/AN individuals of all ages; and, it is 72% higher than the national average. Suicide rates are particularly high among young males in the 15-24 year old age group. In fact, the Centers for Disease Control and Prevention (CDC) reported that from 1999 to 2004, this age group of AI/AN males had the highest suicide rate (27.99 per 100,000), compared to white (17.54 per 100,000), black (12.80 per 100,000), and Asian/Pacific Islander (8.96 per 100,000) males of the same age. Suicide is also the second leading cause of death for AI/AN aged 10-34 years.

The CDC also reports that mental health services are not easily accessible to the AI/AN population due to funding limitations, culturally-inappropriate services, mental health professional shortages, and high staff turnover. For these reasons, AI/AN individuals tend to underutilize mental health services and prematurely discontinue therapy.

Substance Abuse

Although technically categorized as a mental health disorder, substance abuse is considered separately here because of its significant impact on the AI/AN population. The most recent data reported by IHS shows that between 1992 and 2002, alcoholism mortality rates in some tribal communities have increased to nearly seven times the alcoholism death rate of the overall U.S.

population. One of a number of findings associated with alcohol abuse is that of Fetal Alcohol Spectrum Disorder (FASD)—the most preventable cause of mental retardation—which is caused by heavy drinking during pregnancy. Rates of FASD are higher among AI/AN women than the general population. In addition, the drug-related death rate is 18% higher than the rate for the overall U.S. population. Among 12 to 17 year-old AI/AN youth, the 23% rate of current illicit drug use is the highest nationally. Methamphetamine use is also on the rise. It is estimated that a 30% increase in patients seen between FY 2004 and FY 2005 were for methamphetamine use.

Cancer

Despite the fact that the incidence of cancer has tended to be lower among American Indians and Alaska Natives than among other racial groups, AI/AN have the poorest cancer survival rates of any racial group in the United States. Contributing factors include late detection, poor compliance with treatment, the presence of accompanying disease, and lack of timely access to diagnosis and treatment. Within the last 30 years, cancer has become a leading cause of death for AI/AN individuals of all ages.

Injuries, Trauma

Unintentional injuries are the leading cause of death for AI/AN under the age of 44 and the third leading cause of death overall. The age-adjusted injury death rate of AI/AN individuals is approximately 250% higher that that of the general U.S. population. Further, AI/AN individuals experience injuries one and one-half to five times more frequently than non-AI/AN individuals. As a result, IHS spends over $150 million annually treating unintentional injuries.

A recent analysis by the Arizona State University School of Health Management and Policy concluded that Arizona's American Indian children are more likely to experience accidents, homicide, and suicide than are children among all other ethnic groups. Furthermore, deaths among AI/AN children are more likely to be preventable.

"…Arizona's American Indian children are more likely to experience accidents, homicide, and suicide than are children among all other ethnic groups."

Obesity

Obesity is a major challenge to the health status of AI/AN, particularly because of its relationship with Type II diabetes. A variety of studies of AI/AN children and adults confirm a high prevalence of overweight and obesity. One study found that 80% of Arizona's Pima Indians was overweight. The multiple explanations for this circumstance include genetic predisposition and diet. The fact remains, however, that because of the significant role of obesity in the development and course of other conditions, attention to further study and intervention is essential.

Oral Health

American Indians and Alaska Natives continue to experience vast disparities in obtaining oral health services. When compared to the general population, their access to care and utilization of services is markedly limited. Recent figures suggest that approximately 75% of AI/AN

individuals may be going without dental visits, and their rate of oral disease may be twice that of any other group across the nation. Because oral disease, especially periodontal disease, has been linked to other AI/AN health concerns such has diabetes, cardiovascular disease, cancer, and pregnancy outcomes, it is imperative that preventive dental service be provided, whenever possible, to this population.

The prevalence and severity of dental caries among AI/AN children is substantially higher than among non-AI/AN children. A 1999 Oral Health Survey conducted by Indian Health Service indicated that 68% of AI/AN children had untreated decay. Mean scores for AI/AN children with diseased, missing and filled surfaces (DMFS) are over 200% higher than for non-AI/AN children. In addition, children five years of age and younger have early childhood caries rates of 50% to 80%. The rate of dental caries among AI/AN is six times higher that the rate of caries among Caucasians, and the highest of any ethnic group in the United States. The national average rate of caries for all children is under 10%.

Developmental Disorders Affecting Communication: Speech, Language, Hearing

A variety of sources report that communication disorders occur more frequently among AI/AN individuals than among the general population. Some estimate that the frequency of communication disorders occur five to 15 times more in AI/AN, whereas the special education services available for these impairments occur with less frequency. Access to special education professionals is a problem for AI/AN families residing in rural and remote communities in particular.

Health Care Delivery System

Historical Perspective

The health care delivery system for AI/AN individuals is the result of a complex and often inconsistent history of relations between the tribes and the U.S. government. The Kaiser Foundation recently published an issue brief on the roots of AI/AN health care. The brief offers an interesting summary of the legal and historical background against which the AI/AN health care system exists.

Brett Lee Shelton, who prepared the Kaiser document, aptly explains that, as part of an ever-changing landscape, different policies (e.g., termination, assimilation, self-determination) existed during different periods. Following each period, "threads" of doctrine remained, each affecting the current health care system for AI/AN. Tribal sovereignty, government-to-government relations between the tribes and the U.S., and tribal autonomy have been common themes underlying federal-AI/AN relations. In conjunction with these themes, U.S. policy preferences have shifted back and forth between termination, assimilation and self-determination.

In the end, history and policy preferences have played and continue to play a significant part in the delivery of AI/AN health care. Although the federal government has a trust responsibility to provide health care for AI/AN, the system lacks adequate funding, staff, and organization to carry out this task. As a result, public programs, such as Medicaid, have assumed an increasingly important role in the delivery and financing of care to AI/AN.

National Structure and Funding

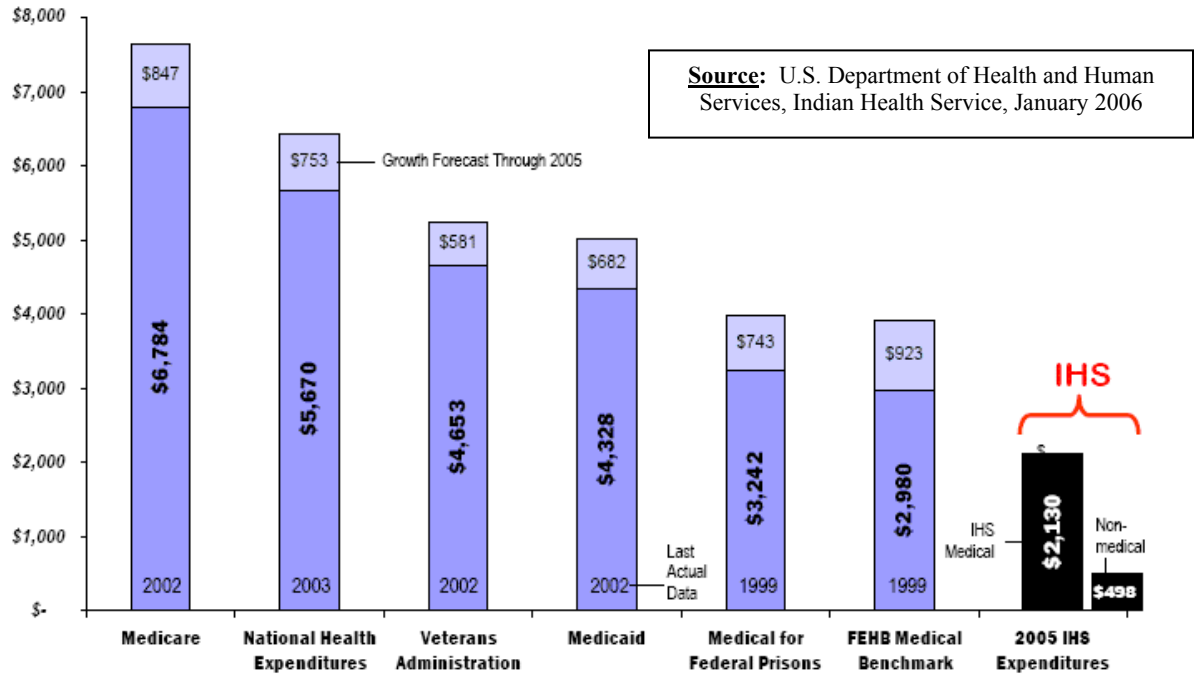
A brief review of the structure and funding of health care for AI/AN provides a clearer understanding of the current service delivery system. In addition to the more frequently discussed social and cultural factors, structural and financial factors play a major role in adequate health care delivery and, for AI/AN, have the potential to either improve the process or contribute to significant health care disparities.

The U.S. responsibility to provide health care to AI/AN populations originated very early in the history of this country as a result of treaty obligations to the tribes. Initially the federal government provided limited health services. In 1832, however, Congress began appropriating funds for health programs for all AI/AN. Currently, Indian Health Service (IHS), a federally funded service within the Department of Health and Human Services, is responsible for delivering health services to AI/AN.

IHS is the principal federal health care provider and health care advocate for AI/AN individuals enrolled in federally recognized tribes. AI/AN individuals living on or near reservations, particularly those in rural areas, are the primary recipients of services. Nearly one million AI/AN individuals are not enrolled with a federally recognized tribe and, thus, are not eligible for IHS services.

Because IHS is a federally funded service provider and not an insurance program, funds are discretionary and not a personal entitlement. Consequently, IHS can provide health care services only to the extent appropriated funding allows. As indicated by the following graph, when IHS funding is compared with that of other federal programs, annual per capita expenditures for AI/AN health care fall noticeably below those dedicated to other federal programs.

2005 IHS Expenditures Per Capita Compared to Other Federal Health Expenditure Benchmarks



IHS operates with funding at about 60 percent of its level of need. To make up the remaining 40 per cent, IHS has placed an emphasis on maximizing third party collections, including reimbursement from Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), and private insurance. One of AHCCCS' primary goals, through the American Indian Health Initiative, is ensuring appropriate billing practices and correct reimbursement to IHS and tribally-operated health facilities funded by the Indian Self-Determination and Education Assistance Act (PL 93-638). Reimbursements for covered services may result in expanded, enhanced, and improved services.

Nationwide, 12 area-based IHS offices administer program operations (e.g., distribute funds, offer technical support), branching out to local administrative units and multiple direct health care facilities (e.g., clinics, hospitals). Arizona is home to three of these offices (Navajo Area IHS, Phoenix Area IHS, and Tucson Area IHS). Additionally, AHCCCS is fortunate to work with over 20 IHS facilities, including one of the nation's major medical centers serving AI/AN.

Within this system, tribes may elect to enter into a contract or compact under the Indian Self-Determination and Education Assistance Act (PL 93-638) to administer health care services for their communities. Tribal programs which are contracted or compacted under P.L. 93-638 are commonly referred to as tribally-operated "638" programs or facilities. IHS and tribally-operated "638" programs use the Contract Health Service (CHS) Program to pay for services that are unavailable at IHS and tribal facilities. However, eligibility and coverage requirements exist for the CHS Program. In most cases, if the patient has coverage through Medicaid, they are ineligible for services covered through the CHS Program.

Role of Medicaid

AI/AN individuals who meet Medicaid categorical and financial eligibility criteria are entitled to coverage. This is the case whether they live on or off a reservation and whether or not they are eligible for IHS, Tribal, or Urban (I/T/U) services. In cases where an individual is eligible for both Medicaid and IHS services, Medicaid is required to assume responsibility for payment. When a Medicaid recipient receives a service provided by IHS that is not covered by the Medicaid benefit package, IHS, as the residual program, is responsible for payment.

Medicaid is an entitlement program for which the federal government matches, on an open-ended basis, state expenditures for covered services provided to eligible individuals. For AI/AN beneficiaries, the federal matching rate is generally 100% for covered services provided in an IHS or tribally-operated "638" facility. Non-IHS Medicaid services are subject to the standard Medicaid match for Arizona. State Children's Health Insurance Program (SCHIP) or KidsCare services are provided at the standard SCHIP Federal Medical Assistance Percentage (FMAP), regardless of venue. AI/AN enrolled in KidsCare are not subject to monthly premiums or co-payments. Although a number of states operate managed care Medicaid programs, federal Medicaid statutes prohibit states from requiring American Indians and Alaska Natives to enroll in managed care.

It is important to note that the Tribal Technical Advisory Group to the Centers for Medicare and Medicaid Services (CMS) has developed a five-year strategic plan for the purpose of improving the health of AI/AN by improving access to Medicare and Medicaid programs. The CMS American Indian and Alaska Native Strategic Plan 2010-2015 includes the following primary goals: (1) Consultation, (2) Policy Formation, (3) Access, (4) Data, and (5) Long Term Care. As

a state agency administering a federal program, AHCCCS strategies should be aligned to support these goals.

The Governor of the state of Arizona issued an Executive Order 2008-07, which authorized AHCCCS to lead a collaborative effort with public health advocates and health care leaders to find solutions for reducing the cost of healthcare for Arizona and improve patient care in the areas of: cancer, heart disease, diabetes, respiratory disease and unhealthy birth outcomes. Healthcare providers and administrators for the IHS and 638 facilities participated in these sessions, offering strategies to improve quality and expand resources for American Indian AHCCCS enrollees in collaboration with other Arizona healthcare providers. Future collaborations and planning with IHS and 638 tribally-controlled facilities should continue to build on this Executive Order.

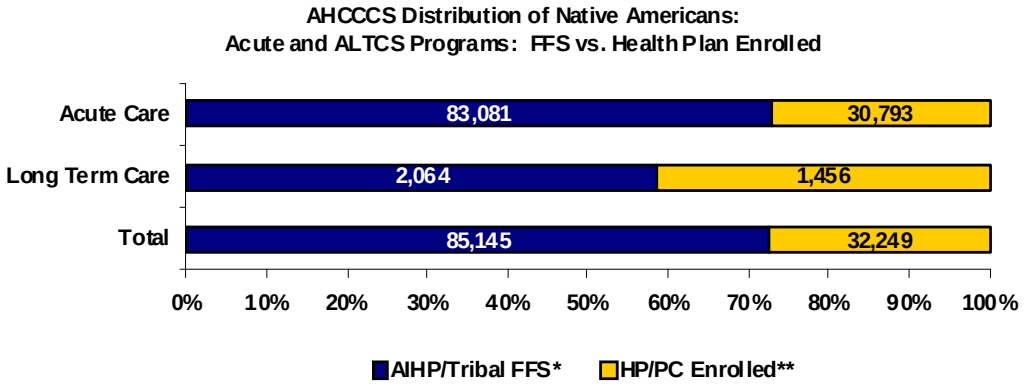
Significance to AHCCCS

AHCCCS services are increasingly important to AI/AN. Although AI/AN have traditionally relied upon IHS for their care, public programs such as Medicare and Medicaid are playing increasingly important roles. These programs support the delivery and financing of health services to individuals residing on or near reservations, as well as to those living in urban areas. As a state Medicaid program serving one of the largest AI/AN populations in the country, AHCCCS serves as:

- An insurance program that covers acute care, including physician, hospital, and other basic health care services for eligible individuals, especially families with children;
- An insurance program that covers behavioral health care, including physician, hospital, therapy, and other basic mental health care services for eligible individuals, especially families with children;
- An insurance program that covers long term care, including physician, hospital, nursing home, and other basic health care services for eligible individuals--especially frail elderly and disabled individuals;
- A source of payment for Indian Health Service (IHS) as well as clinics and hospitals operated by tribes; and
- A source of financial assistance for low-income elderly and disabled individuals in need of assistance to meet Medicare premium and cost-sharing obligations.

AHCCCS has received national recognition for its Medicaid managed care model, which delivers care via contracts with acute care health plans and long-term care program contractors. However, it also supports a fee-for-service program that approves and pays for services provided to AHCCCS members who are not enrolled with an acute care AHCCCS-contracted health plan or a long term care program contractor. AI/AN individuals comprise the majority of this fee-for-service population. This is primarily due to federal requirements that prohibit states from requiring that AI/AN members enroll in managed care. Because AHCCCS complies with this requirement, AI/AN members a given a choice of enrolling with a contracted acute care health plan or the AHCCCS American Indian Health Program (AIHP)—a fee-for-service (FFS) program formerly known as IHS/AHCCCS. Further, AI/AN who select to enroll in contracted health plans are also allowed to seek and receive care from an IHS facility if and when they

choose. American Indians enrolled in the Arizona Long Term Care System (ALTCS) that reside on reservation receive case management services from either their tribe or the Native American Community Health Center.



* AIHP/Tribal FFS = Enrolled with IHS or Tribal Provider – Reimbursed Fee for Service
** HP/PC Enrolled = Enrolled with Contracted Health Plan or Program Contractor
Data as of December 1, 2007

The above figure illustrates that the majority of AI/AN in the acute care program, enroll in AIHP rather than with a contracted health plan. Likewise, the majority of AI/AN in ALTCS are enrolled in the tribal ALTCS fee-for-service program rather than with a program contractor. This FFS program population, plus the managed care plan enrollees who seek care outside their assigned plan (i.e., from IHS), encounter ongoing challenges related to availability of providers and continuity of care.

Tribal Consultation

A unique government-to-government relationship exists among Indian tribes and federal and state governments. The United States recognizes tribal governments as sovereign nations and has enacted numerous regulations that establish and define a trust relationship with Indian tribes. As a state agency responsible for administering a federal program, these regulations play a significant role in the way AHCCCS communicates with tribes in Arizona.

AHCCCS provides health coverage for nearly half of Arizona's AI/AN population. The involvement of Indian tribes in the development of AHCCCS policy allows for locally-relevant and culturally-appropriate approaches to important issues. Pursuant to Executive Order 2006-14, "Consultation and Cooperation with Arizona Tribes," AHCCCS has developed a tribal consultation policy to guide dialogue with Indian tribes in Arizona regarding high-level policy changes that may significantly affect them.

Since the adoption of the AHCCCS Tribal Consultation Policy, AHCCCS has implemented tribal consultation on various programmatic and policy changes. One of the more noteworthy tribal consultation sessions was one jointly conducted by AHCCCS, the Arizona Department of Health Services (ADHS), and the Arizona Department of Economic Security (ADES) in November 2007. The overarching themes of the issues presented by participating tribes at the

Tri-Agency Tribal Consultation Session were (1) funding and resource allocation, (2) program management, and (3) system integration. AHCCCS, together with tribes and pertinent agencies will continue to work on these and other important issues with the overall goal to improve accessibility to quality health care for AI/AN AHCCCS members.

Goals, Key Issues, and Strategies

The following are identified as goals of the American Indian Health Initiative (AIHI):

- Improve AI/AN health status within state/federal policy and guidelines.
- Expand dialogue, partnerships, and collaboration with I/T/Us (Indian Health Service/Tribes/Urban Indian Clinics).
- Ensure correct reimbursement to IHS/638 facilities through appropriate billing for covered services, resulting in expanded, enhanced, and improved services.
- Provide ongoing meaningful tribal consultation on policy and programmatic changes that may significantly affect tribes in Arizona.

As the health care insurance provider for 48% of Arizona's AI/AN population, AHCCCS identified three key issues or areas of opportunity that deserve attention in this initiative:

These three issues impact and are impacted by the four overarching AHCCCS strategic issues: 1) control medical cost inflation, 2) improve health care quality and accessibility, 3) reduce the volume of uninsured, and 4) focus on organizational capacity. These four issues should guide current and future policy and program responses to the three key AI/AN health care issues also identified here.

Additionally, these three issues should be aligned with the IHS Strategic Plan 2006-2012, which has identified three major goals to promote health and prevent chronic disease and conditions affecting the American Indian population:

1. Build and Sustain Healthy Communities
2. Provide Accessible, Quality Health Care
3. Foster Collaboration and Innovation across the Indian Health Network

In response to the three key issues identified, AHCCCS has undertaken a proactive and collaborative partnership with IHS and 638 tribally-operated providers to address each of these three issues. These collaborative efforts are in the form of monthly scheduled meetings, ad hoc meetings and presentations at regional conferences and meetings.

Unique Health Care Needs

The health status of American Indians and Alaska Natives is illustrated by higher rates of disease and shorter life expectancy than the general population. As described earlier, a variety of health conditions are associated with high morbidity and mortality rates among AI/AN. Many of these health conditions are directly affected by individual lifestyle. Some conditions are interrelated in such a way that addressing one condition may prevent or delay the occurrence of others, suggesting the long-range significance of early intervention (e.g., attention to obesity may lead to

a reduction in the incidence of Type II diabetes and, ultimately, prevention of end stage renal disease).

Currently AHCCCS health plans and program contractors engage in a variety of quality management activities to identify and manage high-risk members, including those with conditions prevalent among AI/AN. AHCCCS requires plans to conduct a health status assessment of all new members. For most plans, this process takes the form of a survey, which assists in the early identification and management of conditions that have the potential to benefit from early intervention.

Whereas AI/AN enrolled in acute care health plans may benefit from identification and management strategies such as the one described above, individuals who select to enroll with the American Indian Health Program may forgo some of these advantages. The AHCCCS Division of Fee-for-Service Management (DFSM), which provides oversight of the FFS population that is not enrolled in a contracted health plan, is currently an administrative operation that does not provide disease management services.

With support from a grant funded by the Agency for Healthcare Research and Quality, (AHRQ), AHCCCS and two IHS facilities in Arizona are participating in AHRQ's Medicaid Care Management Learning Network. AHCCCS is working with IHS facilities in Sells and Whiteriver to develop care management strategies for their populations. One possibility, still to be explored, would be a demonstration project whereby AHCCCS would pay and per member/per month capitation to the facilities to reimburse them for care management of their patients.

American Indian ALTCS members that reside on reservations receive case management services through their respective tribe or the Native American Community Health Center. Seven of the 22 tribes in Arizona have an Intergovernmental Agreement (IGA) with AHCCCS to provide case management services to their respective members. American Indian ALTCS members residing on a reservation (excluding those from the seven tribes with IGAs) receive case management services through the Native American Community Health Center. The Native American Community Health Center is contracted with AHCCCS to provide case management services to the remaining 15 tribes in the State of Arizona. The majority of ALTCS members receiving case management services through this fee-for-service model reside in home and community based settings.

Recommended Strategies:

- Collaborate with I/T/Us to identify opportunities to develop and expand culturally-sensitive disease management programs for AI/AN.
- Investigate opportunities for improving the integration of services for AI/AN in the American Indian Health Program.
- Develop regular utilization and quality indicator reports that guide outreach efforts and disease management activities among AI/AN with high-risk conditions.
- Support efforts to educate I/T/U providers and Tribal Governments regarding provisions of legislation that relate to AI/AN health care, particularly those that pertain to Medicaid and SCHIP.

- Support training and professional development of the ALTCS case managers to better develop and monitor appropriate service plans and resolve service barriers, including unanticipated gaps in service delivery.
- Continue monthly web conferences for tribes on topics pertinent to members enrolled in the Medicaid and KidsCare programs.

Availability and Accessibility of Care

A variety of barriers limit the availability and accessibility of health care to AI/AN. Social, cultural, structural, and financial barriers may affect individuals who do and do not receive care from AHCCCS.

Medicaid and SCHIP Enrollment Issues: Despite their eligibility for AHCCCS coverage, a percentage of AI/AN choose not to enroll. The lack of willingness to enroll may result from their understanding, based on past treaties and obligations, that the federal government is required to provide health care without regulations or limitations. They may be uncomfortable with requests for private information, lack trust in federal programs, or be unable or unwilling to produce the documentation that must accompany the application. The process may simply confuse them, or they may lack the transportation to complete applications.

The current insufficiency of IHS funding levels and the eligibility criteria for AI/AN use of IHS services create a need to transcend the barriers and increase enrollment in public health insurance programs such as Medicaid and SCHIP. By enrolling in these programs, AI/AN populations give the I/T/U system—or Indian Health Service/Tribes/Urban Indian Clinics—an opportunity to bill Medicaid or SCHIP for the cost of covered services and expand their network of health care providers. An important factor in this process is the ability of I/T/U facilities to support a billing infrastructure.

Additionally, to address the issue of accessibility to care, AHCCCS, IHS, and the tribally-operated "638" facilities are collaborating to strengthen the business model for Telehealth in Arizona. Representatives from IHS/638s and AHCCCS have discussed opportunities for such improvements that will support IHS and tribally-operated "638" facilities' commitments to Telehealth in Arizona. These discussions have led to clarification of Telehealth service provision and reimbursement that will significantly advance the implementation of Telehealth services across Arizona.

AHCCCS Structure: As previously explained, the AHCCCS structure allows AI/AN to enroll in a contracted health plan or to enroll in the AIHP. AHCCCS pays claims for AI/AN who are enrolled in the FFS program rather than an AHCCCS-contracted health plan; and for those AI/AN who are enrolled in a contracted health plan but obtain care through the IHS and tribally-operated "638" facilities. This administrative arrangement does not support the provision of care continuity and case or disease management. However, AHCCCS authorizes certain services when AIHP members obtain medical care outside the IHS/638 system from an AHCCCS FFS provider.

Network Issues: AHCCCS relies upon a fee-for-service network to provide services, not only to the AI/AN population enrolled in the AIHP FFS program, but also to individuals who qualify for the state's Federal Emergency Services (FES) program. It is, therefore, a consistent challenge to maintain a fee-for-service network that is available, accessible, and culturally competent to serve

the specific needs of AI/AN. Difficulties surrounding service integration and health management for members outside a contracted managed care plan compound the circumstances.

Recommended Strategies:

- Develop and support strategies to improve enrollment of AI/AN in AHCCCS, such as streamlining application processes and supporting more enrollment representatives in I/T/U facilities. AHCCCS has actively promoted the benefits of the web-based Health-e Arizona application in I/T/U facilities and tribes. Several IHS and tribally-operated "638" facilities are using the application to increase the number of AI/AN enrolled in AHCCCS. This, in turn, improves income for those facilities because they can be reimbursed for providing covered services to more AHCCCS members. Improve accessibility to relevant resources, including the member handbook and website, to members and providers of the American Indian Health Program.
- Through an educational approach, brand the AIHP FFS program that can be identified by members and providers. One of the goals of the AIHI is to expand dialogue, partnerships, and collaboration with the I/T/Us. Since the AIHI began in 2005, there have been more than 100 meetings with individual I/T/Us to address specific issues and provide technical assistance, such as,
    - Identifying missed opportunities to bill for covered services;
    - Training staff regarding overall appropriate billing practices;
    - Training staff to work Remittance Advice for eventual payment of claims for covered services; and,
    - Training staff on online claims submission.
- Reduce administrative barriers to health care. One barrier to care was eliminated when AHCCCS made a policy change regarding IHS referrals. Now, a non-IHS provider is no longer required to include an IHS referral when submitting a FFS claim to AHCCCS for services provided to an AI/AN AHCCCS member.
- Collaborate with IHS and the tribes to identify, recruit, and retain a network of preferred providers available to care for the fee-for-service AI/AN population.
- Proactively engage a fee-for-service provider network through support and educational opportunities that include cultural competency training.
- Support development of tribal operations infrastructure in order to enhance the management of health care services.
- Support efforts to improve availability of telemedicine for communities in remote areas.

Data Needs and Information Exchange

Fragmentation of health care data can create significant barriers to effective and efficient care delivery. Information systems should be capable of maintaining administrative functions and continuity of care. Information systems need to be capable of supporting effective data collection for purposes of disease management, evidence-based treatment processes, and community health studies. The current IHS information system requires enhancements to perform these applications.

Except for the KidsCare program, the methodology for claims and encounter reporting between IHS and AHCCCS does not detail procedure information that allows for informed decision-making. Another drawback results from a lack of data coordination and reporting between IHS and independent tribes. As a result of tribal autonomy, not all tribes contribute health data to IHS. This affects the availability and accuracy of information on overall AI/AN health status as well as program administration and funding.

The current billing and payment structure between AHCCCS and IHS does not support the collection of utilization data. At the present time, IHS and 638 facilities are reimbursed at a set rate, published in the federal register, for either inpatient or outpatient services. This method of billing does not capture the actual services provided. Consequently, it is not possible to generate accurate utilization reports from current reporting systems. Details of the services delivered would assist in monitoring utilization patterns and substantiate opportunities to improve the management of member care. Standardized data collection would assist tribes in developing reports, tracking service utilization, and obtaining actual costs. Pertinent data collection by AHCCCS, I/T/Us, and tribal governments is essential when seeking funding to support vital health programs for AI/AN.

When complete and accurate health data are not collected and reported to a central repository, trends in disease incidence, prevention, and treatment are under-reported and may, in the long run, impede progress in eliminating health disparities. Innovative short- and long-term solutions are necessary to improve ultimate health outcomes.

Recommended Strategies:

- Support the gathering and evaluation of health information to facilitate disease management and outcome research, and inform AI/AN health policies and initiatives.
- Enhance data collection efforts for the purpose of developing tribal utilization reports that facilitate the health care management of members; the identification of patterns of care; and, ultimately, network needs.
- Encourage I/T/U facilities in Arizona to participate as data partners of AZ HealthQuery (AZHQ), a statewide database created to facilitate continuity of individual health information across time and delivery systems. AZHQ supports effective disease management and outcome-based treatment programs and contributes to public health information.
- Support the development of an IHS electronic record system, and through their current EHR, identify opportunities for collaboration for data exchange with AHCCCS.
- Enhance IT capabilities and reporting processes to produce patient data by ethnicity.

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